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Kidney Function Tests in Children

CHESTER C. WINTER, M.D., Los Angeles

• **Total renal function is best determined by urinalysis and serum creatinine determination. This may be supplemented, under controlled conditions, by fractional urinary phenosulfonphthalein clearance. The excretory urogram, while invaluable as a diagnostic test, lacks quantitative value as a function test.**

Until recently, individual renal function determinations depended upon the difficult and tedious cystoscopy and bilateral ureteral catheterization and skilled laboratory techniques. Frequently the necessity of anesthesia artificially depressed kidney function.

Since 1956, the radioisotope kidney function test has offered an external, innocuous means of assessing individual renal blood flow, function and drainage plus evaluation of vesico-ureteral reflux. The method has distinct advantages for evaluation of pediatric urological problems.

KIDNEY FUNCTION TESTS may measure total or individual kidney function. The former is assessed more easily and is the usual evaluation. Individual kidney function remains a matter of speculation until procedures peculiar to the specialty of urology are used. This presentation is concerned with an evaluation of certain standard renal function tests and a description of an isotope technique for surveying individual kidney function.

Standard Methods of Determining Total Renal Function

Total kidney function screening is ordinarily performed by means of urinalysis and determination of blood urea nitrogen (BUN) or nonprotein nitrogen (NPN). In most instances, normal values imply normal total function and the kidneys may be dismissed from further investigation. An elevation of urea nitrogen, however, bears further observation, although the abnormal value may merely reflect conditions entirely unrelated to the kidneys, such as dehydration, high protein intake, gastrointestinal bleeding or liver dysfunction. Less commonly used tests include serum creatinine, urinary phenolsulfonphthalein excretion and excretory urography. The latter, while of great value for visualization of renal structure and therefore of diagnostic value, is frequently inaccurate as an index of total renal function. This was explained and illustrated in a recent study,[4] the intravenous urogram having been shown to be especially inaccurate as an individual renal function index in one-third of the patients when a sufficient number of other tests were available for comparison. The explanation is based upon the modern use of huge doses of heavily iodinated contrast media that produce excellent pyelograms indiscriminately, regardless of certain degrees of depression of function. Therefore, normal excretory urograms imply that both kidneys are capable of at least moderate function, although not necessarily equal quantitatively. On the other hand, if the contrast medium cannot be seen in urograms, this usually (but not always) signifies poor total renal function.

Phenolsulfonphthalein (PSP) determinations give a more quantitative answer if the bladder can be emptied at each collection period. The inability of the patient to cooperate due to age or illness may make this test inapplicable without catheterization. In addition to total kidney function, some idea as to the presence of residual bladder urine may be for-

From the Department of Surgery, Division of Urology, University of California Medical Center, Los Angeles 24.

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mulated by a graphic representation of the fractional values of PSP excretion.[2]

Serum creatinine determinations offer the most reliable guide to total kidney function. The amounts do not fluctuate secondary to extra-renal disorders and normally should remain under 1 mg. per 100 cc. in pediatric patients. The per cent of renal dysfunction can be estimated readily and with confidence by dividing the value obtained into 1. There is no increased hardship on the laboratory if this test is performed routinely in large numbers in place of the BUN or NPN determinations.

Standard Methods of Determining Individual Kidney Function

Until 1956 two methods of studying individual kidney function were available. One included roentgen visualization of the renal structure through use of excretory intravenous pyelography (IVP) and/or aortography.[3] An excretory urogram leads to diagnostic evaluation of the renal mass, collecting system and drainage apparatus of the upper urinary tracts. Adequate renal concentrating ability is a necessary prerequisite. Considerable value is placed in the appearance time and concentration of contrast medium in estimating the degree of kidney function. Renal arteriography is indispensable in outlining disturbances in the renal arterial network. Cystography is utilized to reveal vesico-ureteral reflux of urine.

The second method includes cystoscopy and ureteral catheterization.[5] Pediatric patients pose special problems of small, delicate urinary structures and usually the necessity of general anesthesia. Not only can the renal calyces, infundibula, pelves and ureters be outlined by retrograde urography, but urine can be collected from each kidney. The rate of urine excretion can be measured, and also various dye and clearance tests of glomerular-tubular functions and renal blood flow plus osmolarity and electrolyte determinations can be carried out. The results depend upon the ability of the cystoscopist to properly place catheters of adequate caliber, plus the good fortune of adequate urine output and prevention of leakage into the bladder. While dye excretions are estimated with relative ease, the clearance tests (inulin, para-aminohippurate, Diodrast, creatinine, mannitol) require skilled technical and laboratory facilities not generally available. Occasionally ureteral catheterization is impossible and subjective evaluation of the appearance time and concentration of indigo carmine at the ureteral orifices may be the only available means of estimating renal function. This assumes there is no ureteral obstruction and cystoscopy is possible.

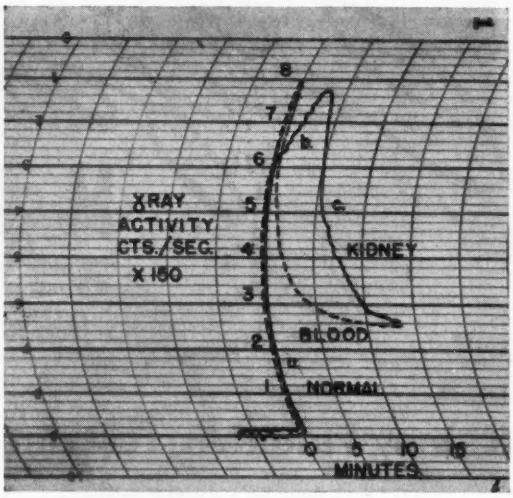

Figure 1.—Simultaneous renogram and blood clearance records show that while the blood is being cleared rapidly, the kidney is actively picking up the radioactive agent as indicated by increase in counts of gamma ray activity per second (γ ray activity cts./sec.).

A New Kidney Function Test

In 1956 a radioisotope technique of testing individual kidney function was introduced and called the radioisotope renogram.[6] The exact location of each kidney is determined by a plain roentgenogram and the patient is placed in the sitting or prone position. A minute amount of contrast medium, tagged with I^{131},[7] is injected intravenously according to a prescribed dosage schedule. At the present time, Hippuran-I^{131} seems the ideal test agent. As the material reaches the kidneys it is selectively removed from the circulation primarily by the renal tubules in a highly efficient manner. A scintillation probe is placed over each kidney posteriorly and the radiation signal is detected and transmitted through electronic rate meters to recorders, where the level of renal radioactivity is transformed into a permanent tracing, immediately available for interpretation. The characteristic normal tracing (renogram) is completed in 10 to 20 minutes and is composed of three segments: (a) An initial spike representing renal vascular capacity, (b) a secondary rise showing degree of tubular cell function and (c) the terminal fall indicative of the ability of the kidney to evacuate urine (Figure 1). In abnormal situations tracings characteristic of decreased arterial flow, tubular dysfunction or urinary stasis are obtained. Experience with over 1,600 renograms shows the accuracy of the isotope test to be comparable to that of the more difficult dye and clearance tests when it is performed properly. There the similarity ceases, since the renogram requires no special preparation, anesthesia, medication, internal manipulation of instruments,

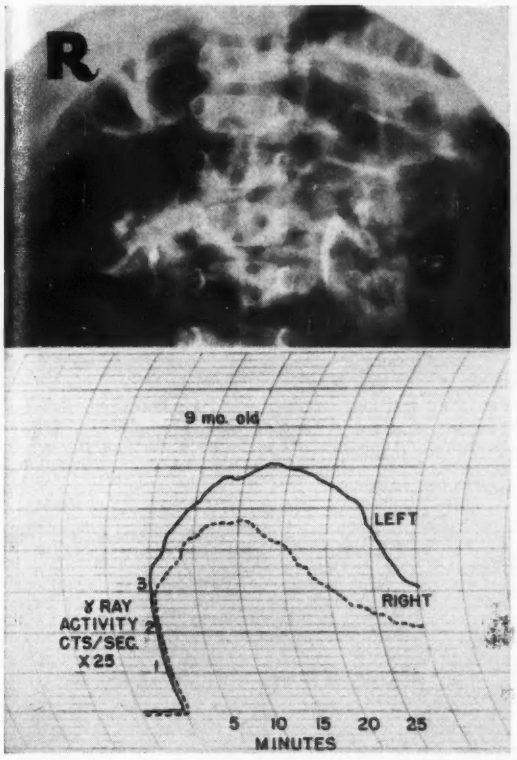

Figure 2 (Case 1).—The intravenous urogram appears normal, although too sketchy for diagnostic accuracy. The radioisotope renogram depicts bilateral normal vascularity, function and drainage of the kidneys.

special laboratory facilities or a long procedure. Furthermore, the renogram can be repeated at frequent intervals, it does not predispose to urinary infections or trauma, and the test agent is innocuous. Adherence to a time-proven technique described elsewhere should prevent artifactual tracings.[9]

As a supplement to the renogram, the radioisotope reflux test was developed.[10] By placing the patient supine with a radioisotope in the bladder and scintillation probes over the kidneys, tracings indicative of vesico-ureteral reflux of urine can be obtained when the condition exists. As the amount of radiation received is negligible, this method is favored over the usual roentgenological practices. Furthermore, with the delayed cystography technique, it is possible for so much absorption of contrast medium by the bladder to occur that renal secretion can cause the pyeloureterograms to have an appearance compatible with false reflux.

ILLUSTRATIVE REPORTS OF CASES

CASE 1. A 9-month-old girl with retarded growth compatible with renal dysfunction had serum creatinine of 0.8 mg. per 100 cc. and BUN of 9 mg. An

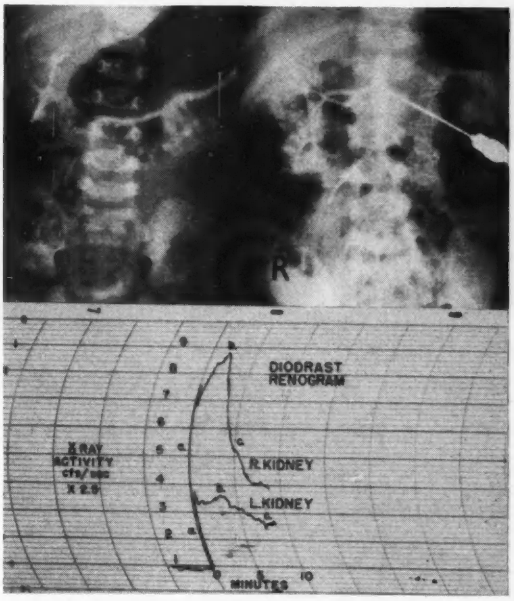

Figure 3 (Case 2).—The intravenous urogram outlines a normal right kidney. The left kidney is not visualized. The aortogram (upper right) shows a normal vascular pattern to the right kidney. The left renal artery and its branches are not revealed. The renogram is normal on the right but shows decreased vascularity and delayed and decreased function on the left. Neither of the latter were reflected accurately by excretory urography or aortography.

intravenous urogram (Figure 2) was interpreted as consistent with prompt function on both sides but was too sketchy to reveal renal size or structure or evidence of disease. Since the result of urinalysis was normal, it seemed desirable to avoid cystoscopy and retrograde pyelography if possible. A radioisotope renogram was made (Figure 2) and found normal, supplying the desired information about the kidneys.

CASE 2. The patient was an 18-month-old boy with hypertension and pyuria. Intravenous pyelography and aortography revealed only one functioning kidney (Figure 3). Indigo carmine appeared normally from the right ureteral orifice but faintly, and delayed from the left. Retrograde pyelograms were normal. The right renogram (Figure 3) was normal but decreased vascularity and function existed on the left (illustrating its value as a screening test among hypertensive persons).[11] Left nephrectomy was done and at last report, three and a half years later, the patient was well.

CASE 3. An 8-year-old girl with hypertension, had right hydronephrosis despite previous pyeloplasty. Aortograms (Figure 4) showed two left renal arteries but only one right renal artery, supplying the upper pole. A renogram (Figure 4)

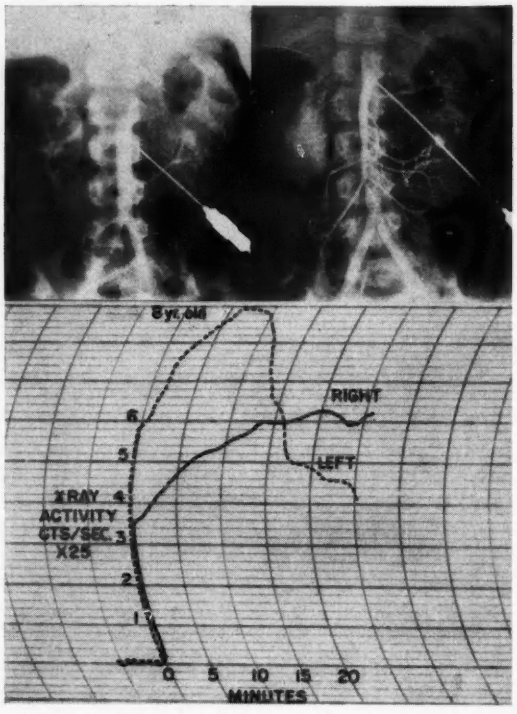

Figure 4 (Case 3).—With the needle lower in the aorta (on the left) only one renal artery is depicted (to lower pole of left kidney). When the aortogram needle is higher up (as on the right), two additional renal arteries are visualized, one to upper pole of each kidney. In the background, a right hydronephrosis can be seen. The left renogram is normal. Both vascularity and drainage are impaired on the right side.

showed a normal left tracing but decreased vascularity and obstruction on the right. Following right nephrectomy, the patient remained well up to the time of last report one year later.

CASE 4. An 8-year-old girl with recurrent urinary infection, had a normal excretory urogram and the chemical contents of the blood were within normal limits. Cystography revealed left vesico-ureteral reflux. This was corrected surgically. A postoperative renogram and isotope reflux test (Figure 5) showed no obstruction or reflux, as was borne out by similar roentgenological studies.

CASE 5. A 16-year-old girl had bilateral uretero-ileal-cutaneous urinary diversion (Bricker procedure) for neurogenic urinary incontinence. The operation had made cystoscopy and ureteral catheterization impossible. Postoperative renograms showed left upper urinary stasis (Figure 6) corroborated by the excretory urograms (Figure 6). A subsequent renogram revealed less stasis. This sequence shows the application of serial renograms for postoperative followup.

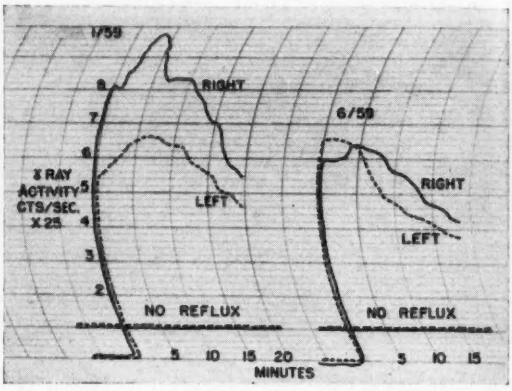

Figure 5 (Case 4).—Postoperative renograms, six months apart, show no impairment of drainage bilaterally. Reflux tracings are superimposed over the bottom of the renograms. They are straight lines, showing no rise as would occur with reflux.

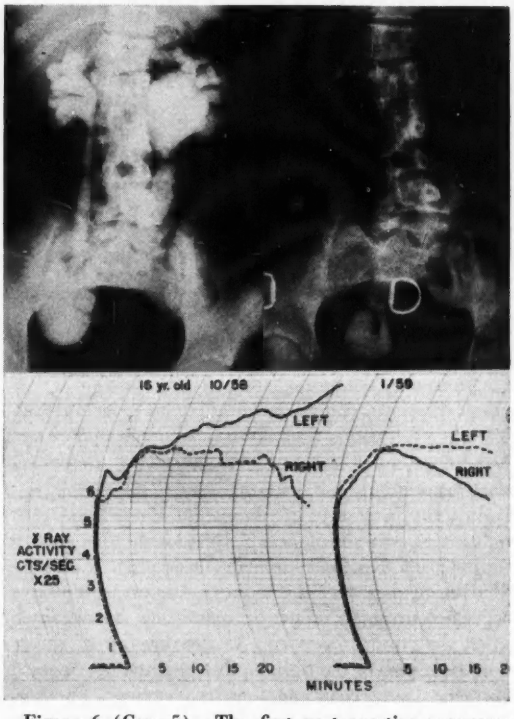

Figure 6 (Case 5).—The first postoperative renogram on the left shows pronounced left and mild right renal stasis. Three months later the renogram on the right showed improvement in renal drainage bilaterally. The early postoperative retrograde (left) and excretory urogram (right) show hydronephrosis bilaterally, more pronounced of the left kidney.

CASE 6. A 10-year-old girl with a solitary left kidney had a serum creatinine of 4.0 mg. per 100 cc. Intravenous urography was contraindicated. Left antegrade pyelography and cystography showed ves-

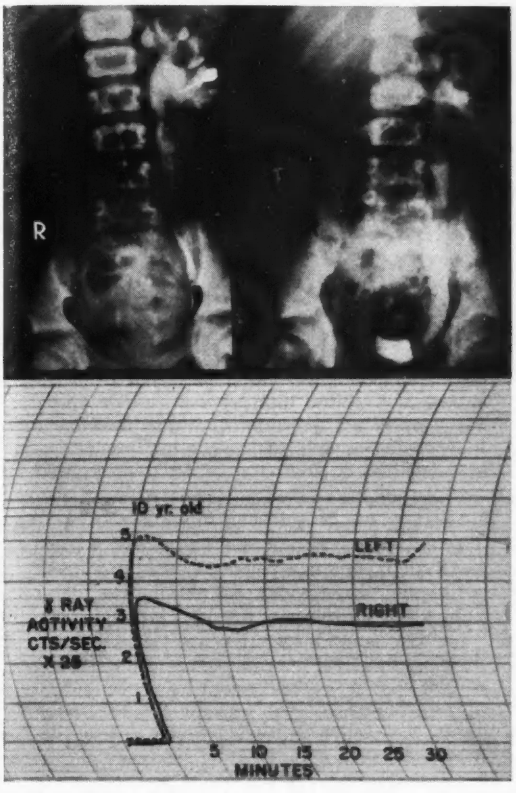

Figure 7 (Case 6).—Left antegrade pyeloureterography shows hydronephrosis and hydroureter. To the right can be seen the patient's cystogram revealing decided vesico-ureteral reflux. The renogram shows lack of functional segments early but stasis is revealed by late rise in the tracings (more so for left kidney).

ico-ureteral reflux and left hydronephrosis and ureterectasia (Figure 7). The renogram (Figure 7) revealed a nonfunctioning or absent right kidney and a poorly functioning left kidney with stasis and azotemia (lack of sufficient drop in terminal right tracing).

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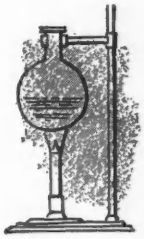

Medical Problems of Amputees

VERNE T. INMAN, *M.D., Ph.D.*, GILBERT H. BARNES, *M.D.*, S. WILLIAM LEVY, *M.D.*, HENRY E. LOON, *M.D.*, and H. J. RALSTON, *Ph.D.*, San Francisco

• **The initial trauma of a major amputation and the medical disorders secondary to it are being studied at the Biomechanics Laboratory. Problems that arise from amputation and from the replacement of the limb by a prosthetic device are complex but interrelated, and approaches to study on basic, applied and clinical levels must be integrated.**

Three studies carried on at the Biomechanics Laboratory are described in this paper.

In the field of amputation operations, it is believed that certain osteoplastic and myoplastic techniques, along with protection for nerve stumps and measures to provide optimum circulatory conditions, may restore biological and mechanical function to a greater degree than is possible with present procedures.

From studies of the expenditure of energy during locomotion with and without assistive devices and during therapeutic exercise, it was found that crutch-walking is metabolically much more costly in energy for the amputee than walking with the suction-socket prosthesis; through these studies, it will be possible to define criteria for maximum work loads for disabled persons.

In dermatological studies, although there are still unsolved problems, successful methods of treatment have been developed for certain bacterial and fungus infections, contact dermatitides and disorders resulting from edema.

PROBLEMS THAT RESULT from a major amputation fall into two categories: Those that are directly related to the amputation, such as pain, circulatory disorders, and secondary skeletal and muscular changes, and those that arise from the attempt to restore function by means of a prosthetic device, such as skin disorders and demands on energy. Therefore, the responsibility of the physician extends beyond mechanical removal of the extremity. It is obvious that he must understand the immediate physiological effects of the surgical operation, but he must also be aware of the impact of the prosthesis on the stump and of the mechanics of the prosthesis itself. All these factors affect each other, and the many problems they give rise to are interrelated and must be studied as such. These problems can be solved only by experts in the various fields working together to achieve rehabilitation of the whole amputee.

Only a few of these problems can be discussed here; therefore, aspects of importance in three areas have been selected: Improvements in surgical procedures, the question of energy expenditure, and problems of effects of the prosthesis on the skin.

TECHNIQUES OF AMPUTATION

Amputation is often the last of a long series of procedures which have proved ineffectual, and the surgeon may often feel the "defeat" that this implies. He may tell the patient that amputation has to be performed to save his life and that modern techniques are such that good prosthesis is virtually assured. With that, he may consider the case closed. For the patient, on the other hand, a new chapter—often including new problems and miseries—begins. Besides the inevitable loss of function that results from amputation, a series of biological changes take place in his body that are also an inevitable consequence of the partial or total loss of the limb. Still other problems become apparent when fitting and use of an artificial limb are considered.

From the Biomechanics Laboratory and the departments of Orthopedic Surgery, Dermatology and Physiology, University of California Medical Center, San Francisco 22.

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Thus the goal of the amputating surgeon should be to restore as far as possible the previous normal functions—both mechanical and biological—not only in the residual extremity but also in the whole body. It may be asked whether surgeons doing such operations are aware of all the problems that occur after amputation and whether they consider them important enough to justify adaptations or changes in amputation techniques.

Over the past 150 years a number of surgeons have attempted to develop techniques that would result in more functional amputation stumps. Many more or less complicated procedures have been advocated, tried, and then discarded. Modern textbooks still recommend the classic method: Simple transection of the bone, more distal sectioning of

the musculature, and formation of one or two skin flaps to cover the distal surface of the bone.

In the Biomechanics Laboratory, we have studied the problem from the point of view of functional loss and biological changes. Our studies have enabled us to set up a number of criteria which, we believe, should bring us closer to the goal of a biologically healthy and functional amputation stump.

Let us review some of the undesirable changes that take place as a result of a standard amputation and consider some ways in which they may be avoided.

The cut end of the bone suffers from avascular necrosis. If, as is customary, no weight-bearing is provided along the axis of the bone (that is, if the amputee bears his weight on some proximal portion of the skeleton rather than distributed over the whole surface of the stump), osteoporosis of disuse results. Proximal joints show thinning of the joint cartilage. Part of the roof of the acetabulum eventually becomes sclerotic. Particularly in children, bones proximal to the amputated bone do not develop maximally, and deformities such as compensatory scoliosis are common.[6]

These changes can be minimized or prevented by an osteoplastic amputation, which provides a good weight-bearing stump. In this procedure, the cut distal surface of the bone is covered with a bone flap. We have tried various types and have had some difficulties with flaps made of a solid piece of bone. Most satisfactory seems to be the procedure developed by the Hungarian surgeon Ertl,[5] who made a flap of periosteum to which chips of bone remained attached (Figure 1). A satisfactory weight-bearing surface is achieved because this material is highly osteogenic and a solid bone cover, or, in the case of the below-knee amputation, a bridge between the tibia and fibula develops. In the latter case, the residual fibula is also stabilized (Figure 2).

In the classic amputation, the belly of the muscle is cut transversely and the residual muscle is allowed to retract. The result is lessening of speed, amount and effective range of shortening; also, atrophy and fatty degeneration may set in below the area of the proximal attachment, creating extremely poor physiological conditions for work.

In a mid-thigh amputation, for example, the muscle groups important for locomotion that are affected are the adductors, the hamstrings, the quadriceps and the iliotibial tract. The hamstrings provide us with a good illustration of the results of the classic amputation: In normal walking, the hamstrings help stabilize the pelvis in the anteroposterior plane and, during swing phase, decelerate the leg just before maximum extension. When the hamstrings are transected and allowed to retract, the energy saved by this function of deceleration is lost. After amputation, the hamstrings often attach themselves to the bone at their distal ends. When this occurs with too little tension, pressure of the prosthetic ischial seat on the ischial tuberosity produces pain; when this occurs with considerable tension or when the muscles are highly developed, the tuberosity is forced off the ischial seat.

Thus, muscles severed during amputation should be anchored distally to the bone by suturing to the periosteum; if they are not, much of their strength will be lost, a prosthetic device cannot be fitted satis-

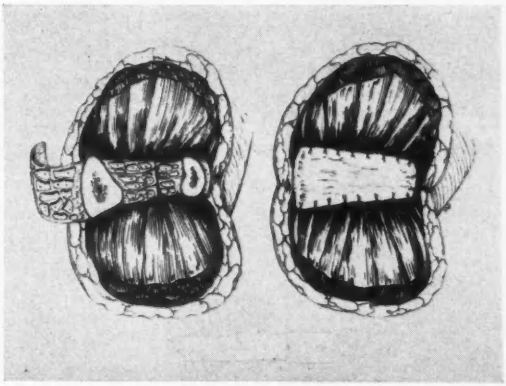

Figure 1.—Ertl's osteoplastic procedure for below-knee amputation. (Modified from *Chirurg.*[5])

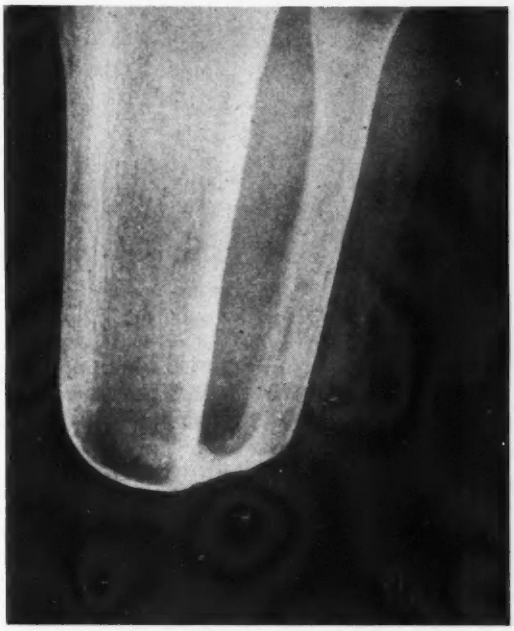

Figure 2.—Roentgenogram showing tibiofibular synostosis resulting from osteoplasty (Ertl procedure).

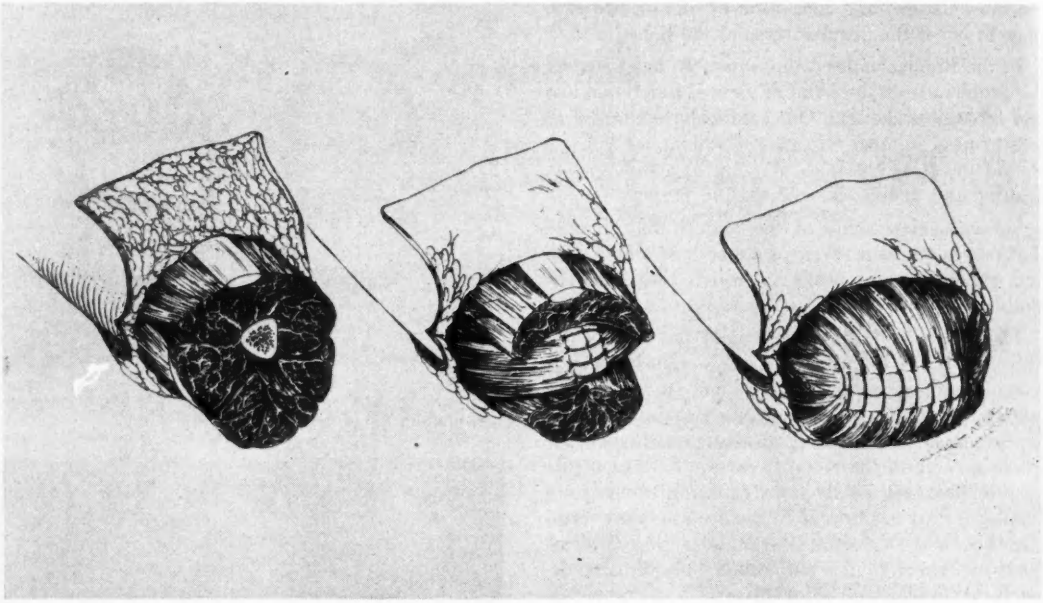

Figure 3.—Mondry's myoplastic procedure for above-knee amputation. (Modified from Chirurg.[8])

factorily and medical problems may arise later because of circulatory deficiencies. Moreover, even better functioning for powering the artificial limb may be obtained by joining the antagonistic muscles to each other as well as anchoring them to the bone. According to Mondry's method of myoplasty, the severed part of the adductors is sutured to the vastus lateralis, and the hamstrings and quadriceps are joined together over and to the underlying muscle layer in the above-knee amputation (Figure 3). A similar method is used in the below-knee procedure.[8]

Circulation is also impaired in the average amputation stump. Oscillogram recordings made by us have shown that there is a reduction in the total amount of blood traversing the stump as compared with the corresponding segment of the intact limb. Perhaps because of this factor, most of the amputation stumps tested became cooler when the ambient air was cooled but did not warm appreciably after warming of the trunk and generalized vasodilatation.[4]

Venous drainage of the stump probably suffers even more than arterial supply. Venous return in the lower extremities, especially when it occurs against gravity, depends to a great extent on the pumping action of the muscles. But we have seen that in the classic amputation the muscles are put to little or no use; if partial or total fatty degeneration takes place, they also form an obstruction to proper circulation. In the bone, too, from which venous blood is normally drained off almost instantaneously, stasis occurs because of the disturbed intramedullary pressure conditions (Figure 4*A*). (The intramedullary cavity is no longer a rigid closed structure.)

These problems, too, are greatly relieved by the use of an osteoplastic-myoplastic procedure. The osteoplastic closure of the medullary cavity restores the original condition of a closed rigid structure (Figure 4*B*). The muscles, which function again, do not degenerate but fulfill their normal function as pumps to aid venous return.

Finally, the problem of pain, both stump and phantom pain, is undoubtedly the most difficult one with which an amputee has to cope. The origins of the different kinds of pain are often obscure. We have used local anesthesia for differential diagnosis: If a low spinal anesthetic eliminates the pain, it seems justifiable to try various surgical procedures affecting the nerves in the periphery in an attempt to alleviate the symptoms. If, on the other hand, the spinal anesthetic has no effect, it may be assumed that the pain originates in higher centers and surgical procedures in the periphery probably would be ineffectual.

How may pain be prevented in the first place? We recommend resecting the nerves high, so that they will not become adherent to scar tissue. We are also experimenting with a procedure (the Boldrey procedure[3]) in which the cut end of the nerve is buried in the bone, being inserted into a hole drilled through the cortex. The advantage of this procedure is that the neuroma, which is usually sensitive to mechanical irritation, is well protected by the hard shell of bone.

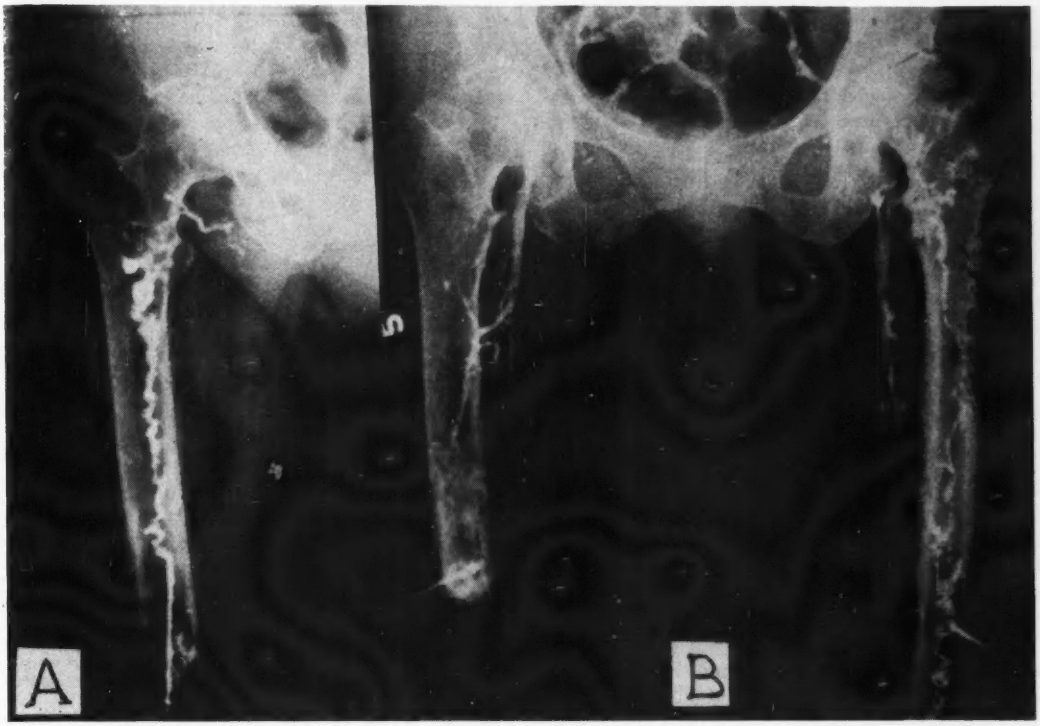

Figure 4.—Venograms of above-knee amputee. *A*, without closure of medullary cavity. *B*, after osteoplastic closure of medullary cavity.

It will be seen from the foregoing that we believe direct partial end-bearing to have many advantages for the health of the amputation stump. Our goal is an insensitive stump that can stand up well to normal mechanical wear and tear. Of course, it is of no use to prepare a stump for end-bearing surgically and then find it impossible to obtain a prosthetic device designed for end-bearing. Ever since the first osteoplastic amputations were done, surgeons have complained of not finding limb makers to fit their patients.

Moreover, it is of utmost importance to insure proper preoperative and postoperative care. Before the amputation, if time allows, everything should be done to achieve optimum conditions of circulation in the extremity. Afterward, immediate appropriate physical therapy measures are imperative to maintain good circulation, prevent muscle contractures and toughen the stump as much as possible for weight-bearing over its entire surface.

METABOLIC DEMANDS OF LOCOMOTION

For the past three years the Energy Laboratory, a subdivision of the Biomechanics Laboratory, has been investigating the problems of energy expenditure of physically disabled human subjects during walking. The first step was to establish normal values of energy expenditure at various speeds. Therefore, during the first year of activity of the Energy Laboratory a study was done of 19 normal adults—12 men and 7 women. It was hoped that a study of normal subjects and a comparison of their energy requirements with those of amputees and other physically disabled persons would provide information that might be useful in evaluating the efficacy of crutches, the suction-socket prosthesis, the pylon and other assistive devices. An additional goal was the definition of criteria whereby one could avoid imposing hazardous work loads on disabled persons—for example, patients with a history of cardiovascular disease.

The measurement of energy expenditure during walking has a long history, but until recently no entirely satisfactory quantitative relationships between energy expenditure and speed of walking had been established. It has proved possible to relate energy expenditure to speed by a rather simple equation, details of which were published in 1958.[9] We will discuss here the general arrangement of the Energy Laboratory and our method of measuring the energy cost of any activity.

A track 24.4 meters in length and octagonal in shape is laid out on the floor of the laboratory. A given subject may be studied during a paced or an unpaced walk, depending on the requirements of the particular experiment. As nearly as possible, subjects are studied under "stabilized" conditions; that is, they have walked long enough to have attained a steady metabolic state. During the walk, pulmonary ventilation is measured with a respirometer of the Max Planck type, which is so small—it weighs 3.5 kg.—that it may be carried on the back of any except the most severely disabled patient. Expired air is collected in a rubber bag and analyzed for oxygen concentration with a Beckman-Pauling oxygen analyzer. From such measurements the volume of oxygen consumed in a given time may be determined, and this figure may be translated into calories of energy expended per unit of time. We have found the most useful way of expressing energy expenditure to be calories per meter walked per kilogram of body weight, and such units will be used in this discussion.

In Chart 1 the lower curve shows the relationship for normal adult subjects between energy expenditure, after stabilization, in calories per meter per kilogram and walking speed in meters per minute. The shaded area represents one standard deviation. It will be seen that the curve starts out with a high figure for energy expenditure at low speeds of walking, comes down through a minimum value for an optimum speed, and then increases again as the walking speed increases. A striking feature of the energy-expenditure curve for any subject walking at a variety of speeds is that it passes through a minimum level that is characteristic for that particular subject. This unique point provides a means of comparing the energy expenditure of the same subject under a variety of conditions or of comparing the energy expenditures of normal and handicapped subjects.

Another fundamental feature of the energy curve is that the optimum speed of walking represents also a "natural" or "comfortable" speed; in other words, a given subject when left to himself tends to adopt a walking speed nearly the same as that at which minimum energy expenditure occurs.

We have made energy studies of a number of above-knee amputees during ambulation in order to compare their energy expenditure during ambulation, when they are using their usual assistive (prosthetic) device, with that of normal subjects and also to compare energy expenditure during ambulation when different assistive devices are used by the same subject.

Referring again to Chart 1, the middle curve shows the energy expenditure of an above-knee amputee walking with a carefully fitted suction-socket prosthesis. The optimum speed of walking, represented by the minimum point of the curve, is substantially less than that for normal subjects; yet the energy expenditure is about 30 per cent greater than that of normal subjects walking at a natural and faster gait. Even so, the suction-socket prosthesis has proved to be the best prosthetic device, from the standpoint of energy expenditure, among the devices so far studied for above-knee amputees.

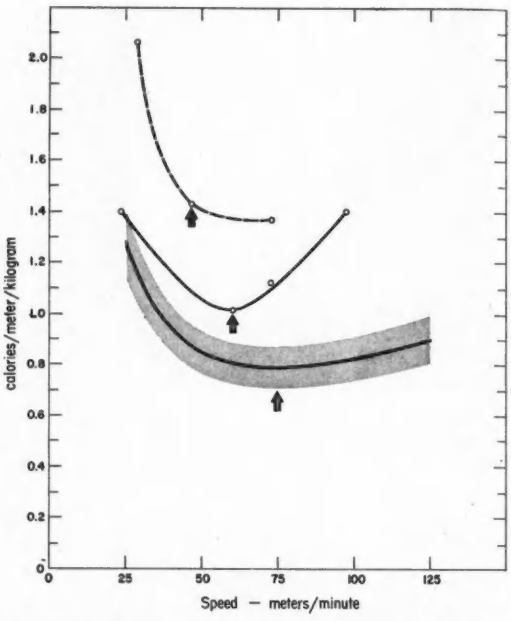

Chart 1.—Comparison of energy expenditure in calories per meter walked per kilogram of body weight of normal persons with that of an above-knee amputee. *Lower curve*, average energy expenditure of normal persons walking at various speeds. *Stippled area*, one standard deviation. *Middle curve*, amputee walking with suction-socket prosthesis. *Top curve*, same amputee walking with forearm crutches. Arrows show natural walking speeds.

The top line in Chart 1 shows energy expenditure of the same subject using forearm crutches. While the optimum speed of walking is not greatly different from that with the suction-socket prosthesis, the energy expenditure is much higher, being about 70 per cent greater than in normal subjects walking at a natural speed and about 35 per cent higher than that of the amputee walking at his optimum speed with the suction-socket prosthesis. Another noteworthy feature of these energy curves is that a wider, as well as more economical, range of speeds is possible with the suction-socket prosthesis than with forearm crutches.

We believe that energy studies of the type just described are capable of yielding information of great

value to surgeons, prosthetists and other persons interested in the problem of rehabilitation, especially of geriatric patients. It is in persons of the latter type that the energy demands of everyday activity are most critical.[1] The repeated finding that crutch-walking is very expensive, from the energy standpoint, would seem to argue against the use of crutches as a suitable assistive device for many patients.

SKIN DISORDERS

The Dermatological Study Group at the Biomechanics Laboratory has been studying skin disorders associated with wearing a prosthetic device. It is common for amputees to have skin disorders at one time or another, and neglect of the smallest of lesions may, in time, lead to serious disability.

Once a leg amputee has become accustomed to wearing his artificial limb, he wants to continue using it, and it is of considerable concern to the physician and the prosthetist—in fact, the entire clinical team—that any disorder that might return him to crutches or to bed rest be prevented. Some amputees have no difficulty with the skin over the stump for months or even years, while others, whose skin is apparently a weak tissue, have frequent skin problems after they begin wearing an artificial limb. Even a minute lesion is important, since it may be the forerunner of an extensive skin disorder which can bring mental, social and economic disaster to the amputee.

Daily hygienic care of the amputation stump and of the prosthetic socket has been found to be of utmost importance. A neglect of cleanliness can easily result in damage to the skin and hence to cutaneous disorders that may force the amputee to forego use of his artificial limb, at least temporarily. In many instances a simple hygienic program, with use of an antiseptic detergent, has helped prevent or eliminate a skin disorder.[2]

The skin problems associated with wearing an artificial leg have been studied, classified and evaluated during the past four years at the Biomechanics Laboratory. Skin disorders that require medical attention fall into several categories, including mechanical injury to the skin, contact dermatitis and other allergic reactions, post-traumatic epidermoid cysts, bacterial and fungus infections, generalized cutaneous disorders that are localized on the stump, edema and conditions that result from it (chronic ischemic ulcers, verrucous hyperplasia) and benign and malignant tumors. Persons concerned with amputees should be aware of certain danger signals, as well as of the pathological conditions they denote. As we will illustrate later, early recognition and treatment may prevent a disabling skin disorder.

Wearing a prosthetic device may also cause mechanical injury to the skin. Abrasion is the first sign that the stump is not being securely held in its socket and that the artificial limb is exerting too much or the wrong kind of pressure on the stump. Areas in which abrasion is most often seen are those over tendons and bones only lightly covered with tissue—the head of the fibula, the tibial tubercle, the anteromedial and anterolateral condyles of the tibia, the anterodistal end of the tibia and the hamstring tendons. Abrasions in these areas are due to settling of the stump deeper in the socket, up-and-down movement of the stump in the socket, tilting of the socket anteroposteriorly or mediolaterally on the stump, twisting of the socket around the stump or too close a fit of the socket over vulnerable areas.

We have seen a number of patients with contact dermatitis of the amputation stump. This disorder is caused by contact of the skin with a substance that acts either as a primary irritant or as a specific allergic sensitizer. To understand this problem, the nature of the plastics and resins used in external and internal finishes of the different types of prosthetic device must be studied. However, in some instances, we have found only by a carefully taken history that the use of a new cream or lubricant or cleansing agent coincided with the onset of the dermatitis. Sometimes a foam-rubber cushion or a plastic-covered pad is used in the bottom of the socket, and these are capable of producing contact dermatitis of the skin after weeks, months or even years of use (Figure 5). When contact dermatitis is suspected, every attempt should be made to determine exactly what caused it. Patch tests are most informative. Removal of the causative agent usually results in cure. In some cases, when the agent causing the contact dermatitis cannot be determined from history or patch testing, temporary therapy alleviates the symptoms; we have found cool compresses, bland antipruritic lotions and the topical use of hydrocortisone or prednisone preparations to be most beneficial.

A number of observers have described the appearance of multiple cysts, commonly called post-traumatic epidermoid cysts, in the skin of an above-knee amputee's thigh. These are thought to be caused by forces of torque or shear exerted on the areas covered by the upper medial margin of the above-knee socket. They also occur, although not as frequently, in below-knee amputees. The cysts may remain quiescent for a long time; then, on the occurrence of secondary bacterial invasion they may become abscessed and the characteristic clinical picture develop. In the phase of acute infection, hot compresses and antibiotics are indicated. As the process localizes, incision and drainage may be temporarily beneficial. In some instances the chronic problem can be improved or successfully eliminated by proper fit and

alignment of the prosthetic device. In our experience, however, there is no completely satisfactory method of treatment, and each case is a therapeutic challenge.

Folliculitis and furuncles may result from poor hygiene of the stump or the socket or both. Chronic recurrent folliculitis has been cured in several cases by following a prescribed routine hygienic program. Use of the antiseptic detergent pHisoHex®, which contains hexachlorophene—a hundred times more effective than soap in eliminating skin bacteria—probably accounts for the success of this program. In other cases therapy may have to include application of wet dressings, incision and drainage of boils after localization, oral or parenteral administration of antibacterial substances and application of local bactericides. Because these stump conditions are frequently chronic or recurring, it is best to choose relatively nonsensitizing substances for topical application.

Bacterial and fungus infections, which are occasionally seen, may be difficult to eradicate completely because of the continued environment of moisture and warmth within the enclosed socket of the artificial leg.

Generalized cutaneous disorders may be localized on the skin of the stump. Those we have seen include acne vulgaris, psoriasis, lichen planus, eczemas and seborrheic dermatitis.

It must be emphasized that, to prevent the development of a disabling skin disorder, lesions must be diagnosed and treatment begun early. For instance, edema of the distal portion of the stump may lead to such additional problems as cutaneous and subcutaneous hemorrhage, stasis eczema, chronic ischemic ulcers or verrucous hyperplasia.

Chronic ulcers (Figure 6) of the stump may result from bacterial infection as well as from poor cutaneous nutrition secondary to an underlying vascular disorder. The underlying cause in all cases should be investigated and appropriate treatment provided. Malignant ulcers can develop within old, persistent stump ulcerations; therefore, every effort should be made to diagnose the condition before it becomes chronic. With repeated infection and ulceration of the skin, the amputation scar may become adherent to the underlying subcutaneous tissues, often causing further erosion and ulceration. Continued wear and tear from use of the prosthetic device may necessitate surgical revision in order to free the scar in the adherent area.

Verrucous hyperplasia also may occur after prolonged edema, and in several instances it has been seen to cover skin of the entire terminal portion of the stump. In cases in which biopsy specimens have been examined, the pathological features of viral verrucae have not been demonstrated, but three factors seem to be involved: An underlying vascular disorder, bacterial infection and poor prosthetic fit and alignment. Treatment frequently consists of adequate control of the bacterial process and gradual end-bearing maneuvers to improve the vascular stasis. A new artificial limb to correct the fit and alignment and gradual compression of the terminal part of the stump to improve the stasis will often alleviate the warty condition or cause it to disappear (Figure 7).

Tumors of the stump may be benign or malignant. We have seen innocent hyperkeratosis, or callus formation, and have removed verrucae, or viral warts, from the stump with use of local anesthesia.

The importance of early recognition and treatment of skin lesions on the stump of amputees cannot be overemphasized. Heavy demands are placed upon the skin of the stump by the artificial leg. Even a minor skin eruption may, through neglect or mistreatment, become an extensive disorder that will deprive the amputee of the use of his artificial limb and seriously affect the progress of his rehabilitation. Services of the entire clinical team are required to provide the maximum benefit to the individual amputee.

Biomechanics Laboratory, University of California Medical Center, San Francisco 22 (Inman).

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PLATE I

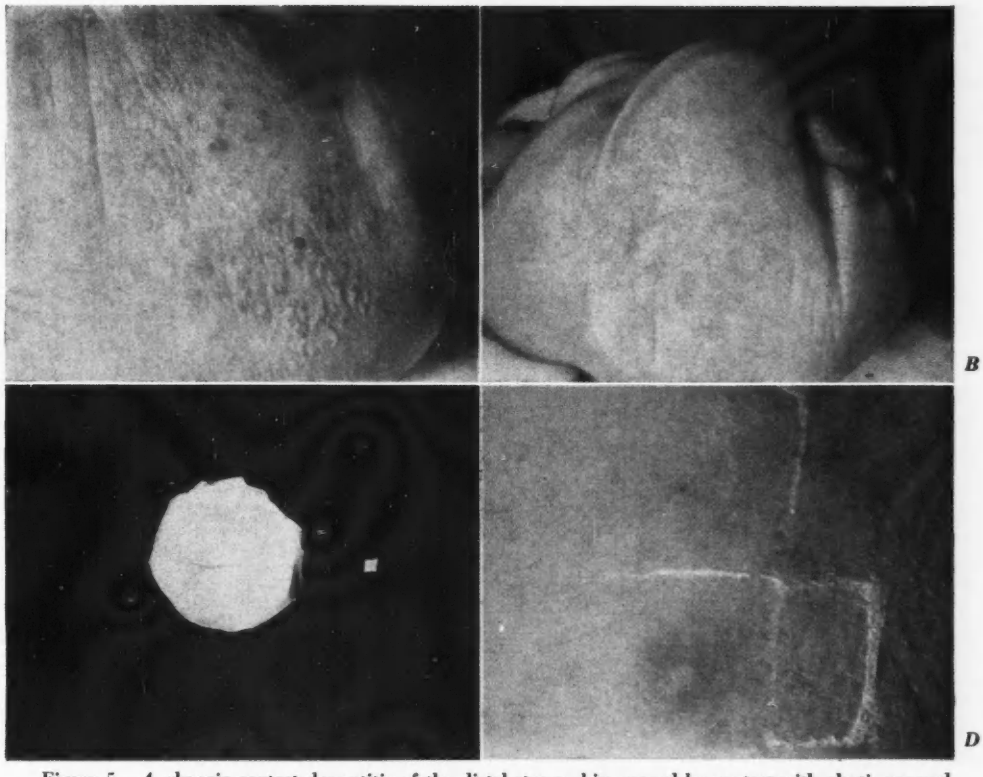

Figure 5.—*A*, chronic contact dermatitis of the distal stump skin, caused by contact with plastic-covered cushion in suction socket. Removal of cushion provided complete clearing in one week. Patch tests were positive for allergic sensitivity to the plastic material. *B*, contact dermatitis of the distal stump skin, caused by contact with foam-rubber pad in socket. Note circular zone of erythema and edema. Removal of pad gave rapid clearing and disappearance of itching. *C*, *left*, foam-rubber pad removed from socket of patient in *B*; *right*, 4-mm. piece of material used in patch-testing. *D*, skin of upper arm of same patient as in *B*, with positive reaction to test for foam-rubber sensitivity. (Reprinted with permission from *Artificial Limbs*.[7])

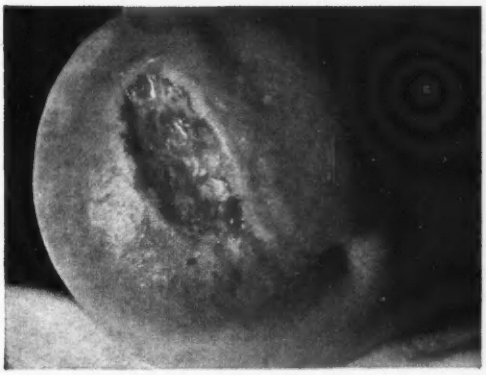

Figure 6.—Chronic ischemic ulcer, caused by poor prosthetic fit with venous obstruction, in 43-year-old below-knee amputee. (Reprinted with permission from *Artificial Limbs*.[7])

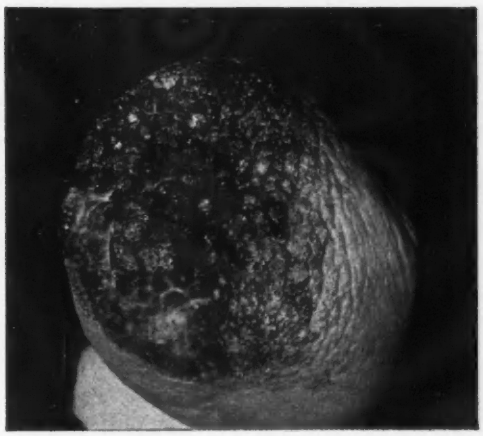

Figure 7.—Verrucous hyperplasia of distal stump skin. (Reprinted with permission from *Artificial Limbs*.[7])

Phonocardiography

E. GREY DIMOND, M.D., and A. BENCHIMOL, M.D., La Jolla

• **In phonocardiography the second heart sound is important in appraisal of congenital heart disease and pulmonary hypertension because it reflects the duration of right ventricular systoles.**

The systolic murmur in patients with intracardiac shunt decreases as pulmonary hypertension develops, and may eventually disappear completely as the pulmonary pressure reaches systemic level.

Reference tracings in phonocardiography are useful for showing the interrelationship of the various cardiac sounds and murmurs.

ADVANCES IN THE surgical treatment of heart disease have made imperative the need for exact diagnosis. Recently developed cineangiocardiography and dye dilution studies, together with data obtained during right or left heart catheterization, potentially afford a great degree of accuracy in the cardiac diagnosis.

Careful auscultation of the heart and modern phonocardiography, however, continue to play an important role in the bedside diagnosis. Correlation of phonocardiographic findings and the altered cardiac hemodynamic features demonstrate that the classic clinical signs of various entities cannot be considered a constant phenomenon. The cardiac sounds undoubtedly vary with the severity of a particular lesion. Careful, precise auscultation continues to have an important part in cardiac diagnosis, however.

HEART SOUNDS

There will be no attempt to describe in detail in the present report the characteristics of normal heart sounds, which have been extensively studied by several investigators.*

The following abbreviations have been employed in the present report: 1—First sound; 2—Second sound; 3—Third sound; 4—Fourth sound; SM—Systolic murmur; DM—Diastolic murmur; ASM—Atrial systolic murmur; A_2—Aortic valve closure; P_2—Pulmonic valve closure; OS—Opening snap; CT—Carotid tracing; VT—Jugular venous tracing; ACG—Apex cardiogram; RV—Right ventricle; LV—Left ventricle; RFW—Rapid filling wave; AA—Aortic area; PA—Pulmonic area; LSB—Left sternal border—4th intercostal space. Vertical lines in the tracings are 0.04 second apart. The tracings were recorded on the Twin Beam (Sanborn) phonocardiograph at the speed of 75 mm. per second. The detailed description of our routine PCG (phonocardiogram) analysis has been described in previous reports.[7,9]

First Sound

The first sound is produced by closure of mitral and tricuspid valves (Figure 1), although in the phonocardiogram four components are often recorded. It is well known that either the mitral or tricuspid component of the first sound may be delayed and/or accentuated in patients with mitral or tricuspid stenosis (Figure 2). In mitral stenosis the left atrial hypertension contributes to delay in the closure of the mitral valve. In some cases of mitral stenosis a reverse split of the first sound might be expected (Figure 3). A loud, sharp and delayed first sound implies the presence of a good, flexible and mobile valve (Figure 2a, b). A small, muffled first sound in patients with unquestionable mitral stenosis indicates the presence of rigid, nonflexible and calcified cusps (Figure 2c, d). Conduction defect, either right or left bundle branch block, can also delay closure of the tricuspid or mitral valves.

With atrial septal defect the increased flow load of the right atrium and ventricle delay the closure of the tricuspid valve and an abnormal split of the first or second sound is recorded consistently.[20] That the right bundle branch block is not the most important factor in production of the split second sound is demonstrated frequently by the continued pattern of right bundle branch block and absence of the split following repair of the atrial septal defect.[9]

Second Sound

A careful analysis of the second sound provides very useful information regarding hemodynamic factors in the pulmonary circulation. In normal young persons a physiological split second sound (aortic component preceding the pulmonic component by 0.03 to 0.04 second) is usually present, and is without pathological significance (Figure 1b). In adults above 25 years of age the second sound is usually single in expiration at the pulmonary area. However, during inspiration the increased venous return to the right ventricle delays the closure of the pul-

From the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla.

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*References 6, 16, 17, 24, 25, 29, 33.

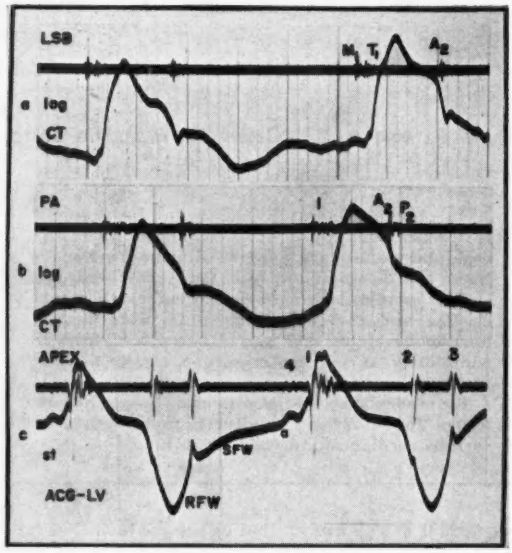

Figure 1.—Phonocardiograms, normal subjects. (a) Physiological splitting of the first sound. Note that both components (M_1 preceding T_1) precede the initial rising in the CT. (b) Physiological splitting of the second sound. The aortic component (A_2) precedes the dicrotic notch of the CT by 0.03 second. The pulmonic component (P_2) which has a smaller amplitude in comparison with A_2 follows the dicrotic notch of the CT by 0.01 second. (c) Quadruple rhythm. Fourth sound preceding M_1 by 0.09 second and is coincident with the peak of the "a" wave in the ACG (atrial contraction) and third sound following A_2 by 0.15 second is coincident with peak of rapid filling wave (RFW) in the ACG. A_2 precedes the beginning of RFW by 0.07 second.

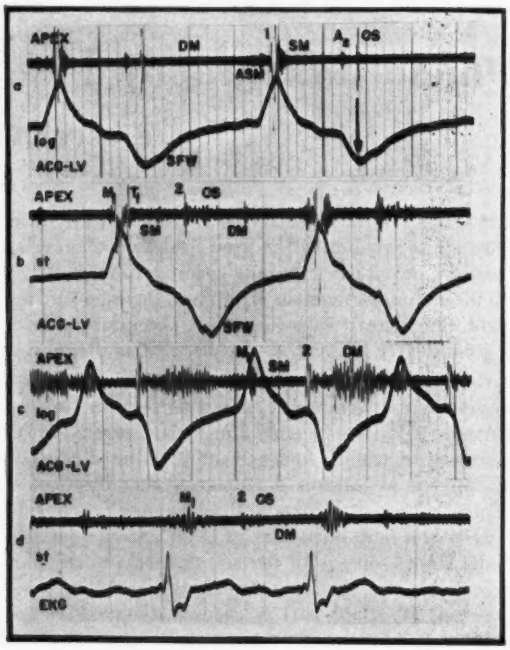

Figure 2.—Different aspects of the first sounds in mitral stenosis. (a) Typical PCG findings of moderate MS. First sound is single and definitely accentuated (compare the amplitude of M_1 with A_2). Note the first sound which is coincident with the peak of the systolic wave in the ACG and opening snap coincident with the beginning of the left ventricular filling (2-OS interval = 0.08 second). Low pitched diastolic murmur and atrial systolic murmur. Apex cardiogram without rapid filling wave (SFW = slow filling wave). (b) Split first sound. Loud M_1 preceding T_1 by 0.04 second. OS follow A_2 by 0.09 second. Long diastolic murmur and high pitched decrescendo systolic regurgitant murmur. Absence of RFW in the ACG. (c) Mitral stenosis with severe calcified mitral valve. Single and diminished first sound. Opening sound not recorded. High amplitude, long diastolic murmur. No atrial systolic murmur (auricular fibrillation). (d) Mitral stenosis with calcified valve. Single and diminished first sound. The Q-1 interval (beginning of the QRS in the EKG to M_1) is prolonged to 0.10 second. Note the presence of opening snap (2-OS interval = 0.06 second) in the presence of calcified valve. Long diastolic murmur. No atrial systolic murmur (auricular fibrillation).

monary valve and a split of the second sound can be present.[7]

The closure of the pulmonary valve (P_2) seems to depend on several factors: Mobility of the valve, diastolic pressure in the pulmonary artery, pulmonary flow and resistance. Alteration of these factors, alone or in combination, will result in an abnormal pulmonic second sound.

Valve rigidity and the low diastolic pressure in the pulmonary artery with pulmonary stenosis are factors responsible for the delay in the closure of the pulmonary valve. The widely split second sound with diminished pulmonic component is characteristic of the condition. The A_2—P_2 interval seems to give useful information regarding the pressure gradient across the pulmonary valve, interval increasing as the pressure gradient increases[2,22] (Figure 4). Absence of the pulmonary second sound in patients with pulmonary stenosis indicates a considerably diminished pulmonary flow, and constitutes an important sign in patients with severe tetralogy of Fallot and large right to left shunt.[2] Pulmonary hypertension due to atrial septal defect, ventricular septal de-

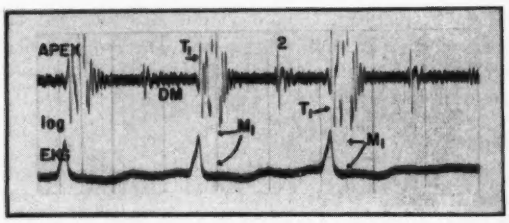

Figure 3.—Mitral stenosis. Reversed split of the first sound. Note that the loudest vibration (M_1) follow T_1 (reverse of normal). Observe that T_1 follow the R wave in the EKG and note also that the patient has auricular fibrillation. These two factors rule out the possibility of the first component being the atrial contraction. Long diastolic murmur.

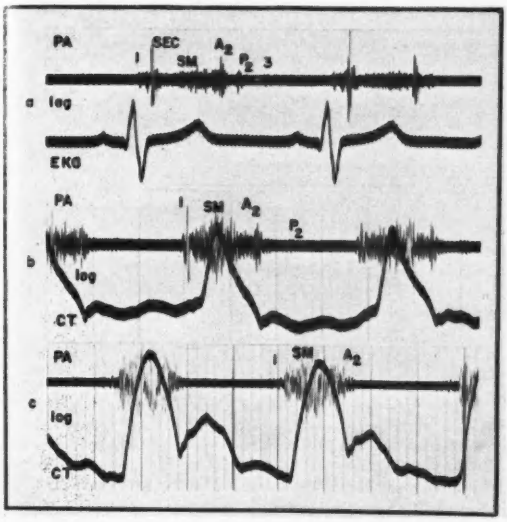

Figure 4.—Second sound in isolated pulmonary valvular stenosis. (a) Mild pulmonary stenosis. Pressure gradient RV-MPA—40 mm. Hg. A_2-P_2 interval 0.07 second and diminished P_2. Third sound. Systolic ejection click following the first sound by 0.07 second. Pulmonary systolic ejection murmur with mid-systolic accentuation. (b) Moderate pulmonary stenosis. Pressure gradient RV-MPA—100 mm. of mercury. A_2-P_2 interval 0.14 second. P_2 decidedly diminished. A_2 precedes the dicrotic notch in the CT by 0.02 second and P_2 follow it by 0.12 second. Pulmonary systolic ejection murmur with mid-systolic accentuation going through A_2. (c) Severe pulmonary stenosis. Pressure gradient RV-MPA—130 mm. of mercury. P_2 is absent. A_2 cannot be well identified because the murmur goes through. Pulmonic systolic ejection murmur with mid-systolic accentuation.

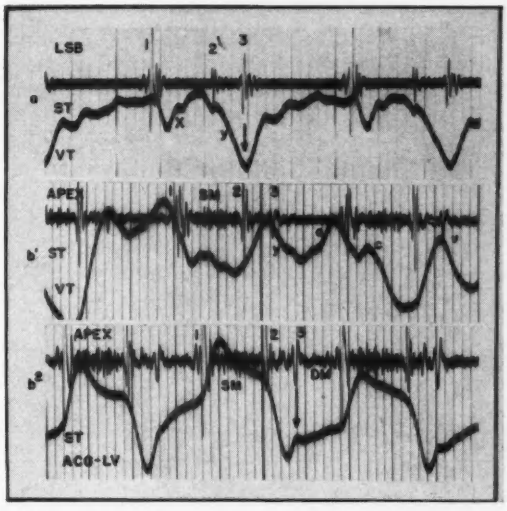

Figure 5.—Third sound. (a) Right ventricular third sound in case of proved constrictive pericarditis. Note that the third sound is coincident with the end of "y" descent in the VT which marks the end of rapid filling period of the right ventricle. (b^1 and b^2) Left ventricular third sound in patient with ventricular septal defect without significant pulmonary hypertension. MPA pressure 35/10 mm. of mercury. Note in b^1 that the third sound follow in the beginning of "y" descent in the VT. In b^2 (same patient) the third sound is coincident with the peak of the RFW of the left ventricular ACG. Pan-systolic regurgitant murmur and mid-diastolic murmur.

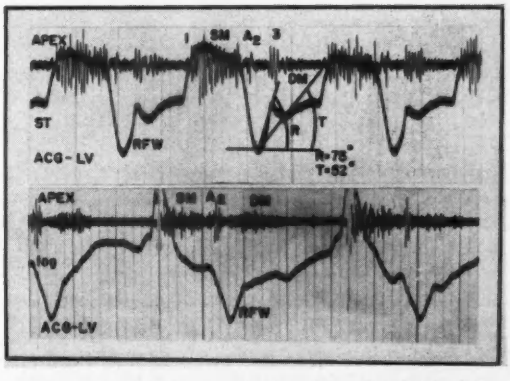

Figure 6.—Mitral regurgitation. *Top*—Diminished first sound. Third sound coincident with the peak of the RFW in the left ventricular ACG. (R-75°, T/R-0.69) Mitral systolic regurgitant murmur. Short mid-diastolic murmur. *Bottom*—First sound somewhat accentuated. Mitral systolic regurgitant murmur. Mid-diastolic murmur. The systolic murmur and the presence of RFW in the ACG suggest that the dominant lesion is mitral regurgitation.

fect, patent ductus arteriosus or primary pulmonary hypertension and other conditions produces the opposite phenomenon,[3,15,32] as observed in pulmonary stenosis. Our previous report[3] on patients with ventricular septal defect and pulmonary hypertension indicates that a high diastolic pressure of the pulmonary artery produces shortening of right ventricular systole and early closure of the pulmonary valve. In this situation the second sound is usually single or very closely split (no more than 0.02 second). With increasing pulmonary artery pressure due to rising pulmonary resistance, the right ventricular systole is so short that a reverse split of the second sound might be expected. This phenomenon, which we called "pulmonary reverse split,"[3] is the opposite of "aortic reverse split," which is due to prolongation of left ventricular systole, as occurs in cases of aortic stenosis,* essential hypertension and left bundle branch block.

In patients with atrial septal defect a wide split second sound is present.[1,9,11,23] This is most probably due to the pronounced increase in pulmonary flow from the left to right atrial shunt. If pulmonary hypertension develops,[35] however, with balance shunt, the widely split second sound reverts to a single and accentuated second sound.[9]

*References 4, 8, 12, 18, 28, 34, 41.

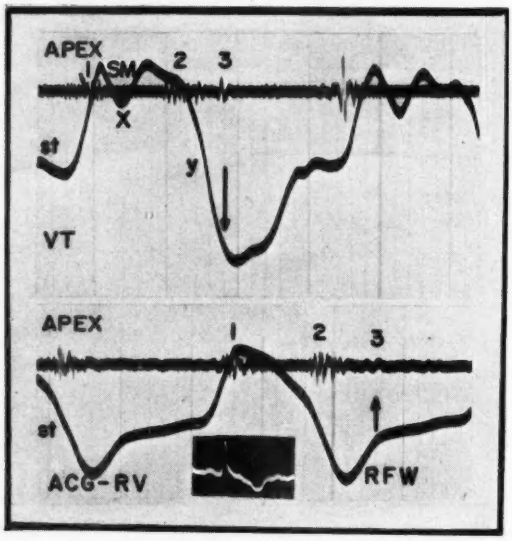

Figure 7.—Right ventricular third sound. Mitral stenosis with severe tricuspid regurgitation. MPA pressure 120/50 mm. of mercury. *Top*—Diminished first sound. Note that the third sound is coincident with end of "y" descent in the VT. Sustained systolic wave with very small "x" descent. Systolic regurgitant murmur. *Bottom*—Right ventricular ACG. Note that the third sound is coincident with the peak of ACG. At the point where the ACG was recorded the electrocardiogram revealed right ventricular complexes (position between V_1 and V_2).

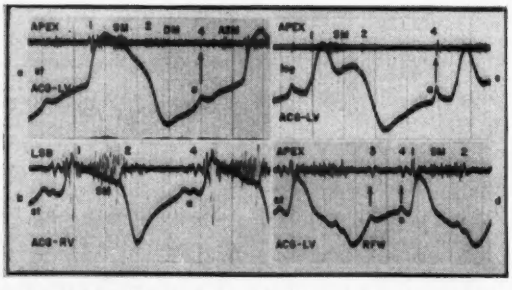

Figure 8.—Fourth sound. (a) Aortic stenosis and insufficiency with first degree of AV block. Note that the fourth sound is coincident with the peak of the "a" wave in the left ventricular ACG. The "a" wave as well as the fourth sound is 0.27 second before the first sound (AV block). Short atrial systolic murmur and an ejection mid-systolic murmur. Arterial diastolic murmur well recorded at the apex. Note that this murmur starts immediately after the second sound and before the beginning of RFW in the ACG. Sustained systolic wave in the ACG. (b) Severe pulmonary stenosis. RV pressure 230/0 mm. of mercury. MPA pressure 15/5 mm. Loud right ventricular fourth sound coincident with the peak of "a" wave in the ACG. Pulmonic systolic ejection murmur. (c) Severe aortic stenosis. Loud fourth sound coincident with the peak of "a" wave in the ACG. Aortic systolic ejection murmur. Note double systolic wave in the ACG. Compare with the ACG on "a." (d) Mitral regurgitation with third and fourth sound. Fourth sound (unusual in MR) coincident with the peak of the "a" wave in the ACG. Third sound coincident with the peak of the RFW in the left ventricular ACG. Systolic regurgitant murmur.

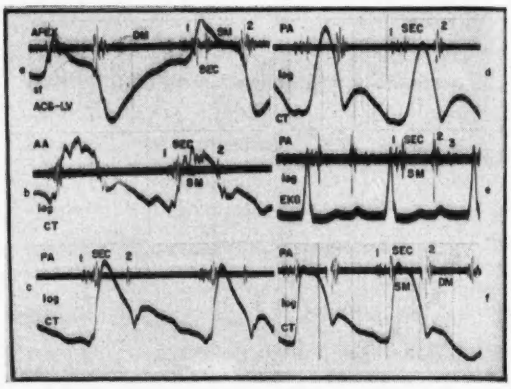

Figure 9.—Systolic ejection click in various heart diseases. (a) Mitral stenosis with pulmonary hypertension. Single first sound. The click is recorded 0.06 second after the first sound. Note that it follows the peak of the systolic wave in the ACG. Long diastolic murmur. Systolic regurgitant murmur. No RFW in the ACG. The patient had a "fish mouth" valve at surgical operation with stenosis and regurgitation and pronounced dilatation of the pulmonary artery. (b) Aortic stenosis. Systolic ejection click follows the first sound by 0.07 second and occurs during the upstroke of the CT. Note the carotid shudder in the CT and prolongation of the total ejection time and upstroke time. Aortic systolic ejection murmur. (c) Idiopathic dilatation of the MPA. The click occurs 0.08 second after the first sound at the upstroke of the CT. No intracardiac shunt was demonstrated at cardiac catheterization. Pronounced dilatation of the MPA was shown in an X-ray film. (d) Primary pulmonary hypertension. MPA pressure—140/55 mm. of mercury with dilatation of the PA. The click occurs 0.08 second after the first sound. No murmurs. (e) Truncus arteriosus. The click is close to the first sound (0.04 second) with first degree AV block in the EKG. (f) Atrial septal defect with severe pulmonary hypertension. MPA pressure 90/30 mm. of mercury. Pulmonary regurgitation. The click follows the first sound by 0.09 second and occurs at the upstroke of the CT. Loud second sound and arterial diastolic murmur.

We have been unable to consistently demonstrate the so-called "fixed split" of the second sound in cases of atrial septal defect without pulmonary hypertension.[9] There is, however, a certain degree of truth in this statement. This phenomenon depends primarily on the amount of left to right shunt. The fixed split may be present in cases of a large left to right shunt, the shunt preventing the normal increase in the venous return during inspiration. The normal split will occur if the shunt permits. The second sound split was considered to be fixed in only 9 out of 32 cases of atrial septal defect, there being no appreciable change in the A_2—P_2 interval during inspiration.[9]

The transmission of the pulmonary component of the second sound to the apex seems to indicate dilatation of the right ventricle, and is commonly observed in patients with tricuspid regurgitation, atrial septal defect and allied situations.[9]

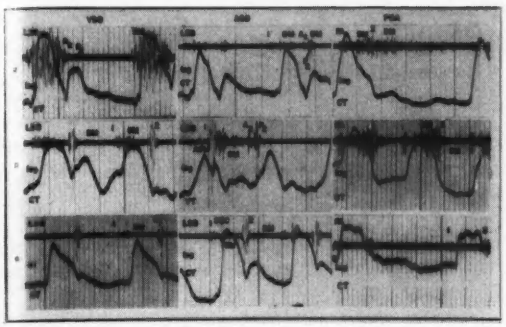

Figure 10.—Murmurs and heart sound in congenital cardiac shunt and PDA. (a) Without pulmonary hypertension. (b) Moderate pulmonary hypertension. (c) Severe pulmonary hypertension.

VSD: (a) Note the systolic murmur beginning immediately after the first sound and ending at A_2. Second sound is split by 0.09 second. This patient had functional infundibular obstruction (muscular hypertrophy of the outflow track of the RV) at surgical operation. (b) Short systolic murmur and a single and loud second sound. Note that the second sound occurs before the dicrotic notch of the CT. (c) Short and very low amplitude systolic murmur with single and loud second sound which occur before the dicrotic notch of the CT (shortening of the RV systole).

ASD: (a) Systolic ejection murmur with widely split second sound (A_2-P_2 interval 0.06 second). Note shortening of the left ventricular ejection time in the CT (0.22 second). Short arterial diastolic murmur due to dilatation of the PA (Graham Steell's murmur). (b) Loud first sound. Decrescendo systolic murmur going through A_2. Widely split second sound (0.10 second) with accentuated P_2. Note prominent "v" wave in the VT. Atrial systolic murmur. (c) Loud click and single and loud second sound. Short and low amplitude systolic murmur. Arterial diastolic murmur.

PDA: (a) Typical continuous murmur. (b) Note that the diastolic component of the murmur is very low amplitude and no longer occupies all diastole. (c) "Silent" PDA, no murmur.

Third Sound

The third or diastolic filling sound is a perfectly normal event in the cardiac cycle (Figure 1c) and is exaggerated in certain noncardiac pathological conditions such as anemia and hyperthyroidism.[19,27]

The pathological third sound, again an exaggeration of the normal third sound, and without identifying characteristics, is present in heart failure, resulting in the classic rhythm of protodiastolic gallop.[10,40] This sound is exaggerated in any condition which increases the filling of the right or left ventricle. It is in this context that it is found in patients with diastolic overload of the right or left ventricle as in mitral or tricuspid regurgitation[14] (Figures 6, 7), ventricular septal defect,[3] atrial septal defect,[9] and patent ductus arteriosus. The third sound is a bedside aid in evaluation of the amount and direction of the shunt in ventricular septal defect, atrial septal defect and patent ductus arteriosus. As previously demonstrated,[3] patients with ventricular septal defect and dominant left to right shunt usually present a diastolic filling sound and a short mid-diastolic rumble due to increased flow across the mitral valve (Figures 5b[1], b[2]). If, however, pulmonary resistance and consequently, pulmonary hypertension develop to produce a balanced pressure in the ventricular chamber, the diastolic overload of the left ventricle is no longer present, and consequently, the third sound as well as the mid-diastolic rumble will disappear.

In patients with mitral stenosis due to decrease of rapid filling period (characterized in the apex cardiogram by disappearance of rapid filling wave[5,13]) the left ventricular third sound is seldom recorded (Figure 2).

The value of the third sound in constrictive pericarditis[30] (Figure 5a) and Ebstein's disease[27] is well known and will not be discussed in this report.

Fourth Sound

The fourth sound,[38] due to atrial contraction, is an unusual finding in a normal person, although it may be present occasionally (Figure 1c).

A pathological fourth sound is usually associated with right or left ventricular hypertension, as in aortic stenosis, essential hypertension, pulmonary stenosis and pulmonary hypertension (Figure 8). It can also be present in cases with auriculoventricular block of any degree (Figure 8a). When found in association with pulmonary stenosis it seems to correlate very well with the degree of right ventricular hypertension, and is most commonly seen when the ventricular septum is intact.[2] The presence of ventricular septal defect as an associated lesion relieves the right ventricular pressure (acting as a safety valve) and consequently produces a lesser strain on the right atrium.

Clicks

Leatham and Vogelpoel[21] described the presence of an early systolic sound in patients with dilatation of the pulmonary artery. Since then, numerous reports[21,26] have shown the systolic ejection click as a fairly constant finding in patients with minimal to moderate pulmonary stenosis, idiopathic dilatation of the pulmonary artery, tetralogy of Fallot, essential hypertension, etc., all conditions commonly associated with dilatation of the pulmonary artery or the aorta (Figure 9).

The mid or late systolic click continues to be an unexplained sign, and is usually heard in normal persons.

Murmurs

Modern phonocardiography has brought about the development of a new classification of cardiac murmurs, which better describes them in relation to their origin and the total dynamic complex of the

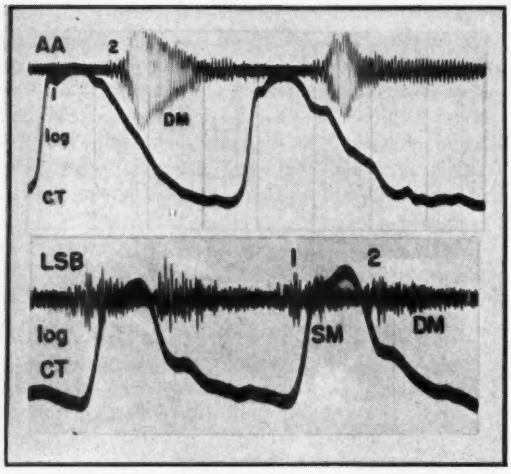

Figure 11.—*Top*—Aortic insufficiency. Syphilitic aortic insufficiency with rupture of aortic cusps. Note typical arterial diastolic murmur starting immediately after the second sound. Observe also the musical quality of the diastolic murmur as well as the absence of dicrotic notch in the indirect CT. *Bottom*—Pulmonary regurgitation in patient with ventricular septal defect and severe pulmonary hypertension (MPA = 80/30 mm. of mercury). Arterial diastolic murmur starting immediately after the second sound. Short systolic murmur.

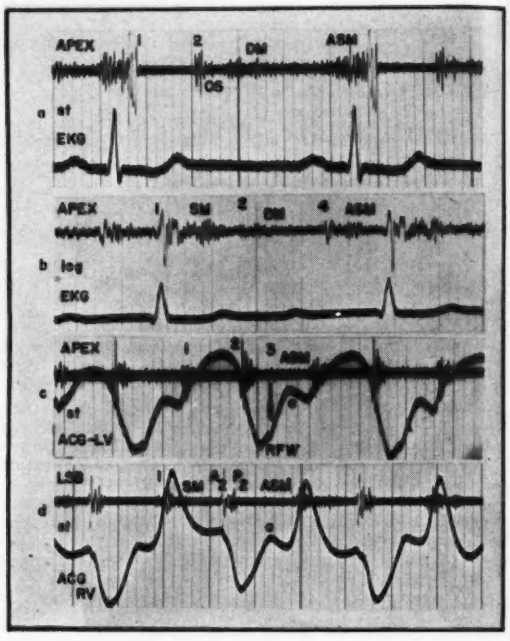

Figure 12.—Atrial systolic murmurs. (a) Mitral stenosis. Typical PCG findings of MS. Loud, single and delayed first sound (Q-1 interval = 0.10 second) 2-OS interval 0.06 second. Atrial systolic murmur beginning after the P wave in the EKG with maximal intensity at the peak of R wave. Delayed mitral diastolic murmur fading before the P wave in the EKG. (b) Aortic stenosis and insufficiency with first degree AV block. The long P-R interval favor the contraction of the left atrial and gives rise to a left atrial systolic murmur. Aortic systolic ejection murmur. (c) Idiopathic myocarditis with left heart failure. Diminished first sound. The third sound coincident with RFW in the ACG. Atrial systolic murmur which follows the very prominent "a" wave in the ACG. (d) Atrial septal defect without pulmonary hypertension. Second sound split by 0.05 second and P_2 is normal. Note that both components of the second sound precede the RFW in the ACG. Atrial systolic murmur which follows the "a" wave in the ACG. Normal first sound.

heart. A proper classification should enable one to recognize the origin of the murmur from its description.

Systolic Murmurs

Systolic murmurs may be classified as to whether they are caused by ejection of blood across the pulmonic or aortic valve, or by regurgitation across the atrial ventricular valves or a septal defect.

A. *Ejection Murmur:* The systolic ejection murmur of pulmonary stenosis, aortic stenosis or atrial septal defect has characteristic phonocardiographic features.[9,20,37] These murmurs present certain typical characteristics, which are influenced by hemodynamic changes in the heart. For example, the murmur of mild pulmonic stenosis with midsystolic accentuation differs from that of severe pulmonary stenosis in accentuation, duration and time of beginning and ending (Figure 4). Phonocardiography has made significant contributions in this particular area.

B. *Regurgitant Murmurs:* Mitral and tricuspid regurgitation are typical examples of regurgitant murmurs (Figure 6). It has been demonstrated in these conditions that the duration of the murmur has good correlation with the degree of regurgitation. Severe mitral or tricuspid regurgitation produces a pansystolic murmur, while minimal to moderate regurgitation is associated with an early or late systolic mumur. Ventricular septal defect murmurs, although not typical regurgitant murmurs, should be included in this classification.[27] In a previous report,[3] we pointed out that a ventricular septal defect presents a pansystolic murmur, if the pulmonary pressure is below 50 to 60 per cent of the systemic pressure (Figure 10). In pulmonary hypertension, as pulmonary pressure approaches the systemic level, the murmur is usually confined to early systole, and may eventually disappear completely (Figure 10b, c). This is due to the progressive decrease in the amount of left to right shunt, to a point where the shunt is no longer present. The same phenomenon occurs in cases of atrial septal defect and patent ductus arteriosus, in which increased pulmonic pressure develops and causes a progressive decrease in left to right shunt, with eventual cessation of the shunt and the murmur, as

the right ventricular pressure approaches systemic pressure (Figure 10).

Diastolic Murmurs

A. *Arterial Diastolic and Atrioventricular Murmurs:* The diastolic murmurs are caused by regurgitation across the pulmonary valve, aortic valve (Figure 11) and by flow across a stenotic mitral or tricuspid valve[27,36,37,39] (Figure 12). Phonocardiography has made little contribution in the arterial diastolic murmurs of aortic regurgitation and pulmonary regurgitation, due to the difficulty of recording these high pitched low-energy sounds. However, it appears that the duration of the murmur increases with the amount of regurgitation. This same concept may be applied to the atrioventricular murmurs of mitral and tricuspid stenosis. It has been demonstrated that increased flow across the atrioventricular valve causes a diastolic murmur.[9,11,31]

The presence of a diastolic rumble at the apex in a ventricular septal defect and patent ductus arteriosus, indicates the presence of a dominant left to right shunt with large recirculation of blood across the mitral valve. Pulmonary hypertension, which decreases the left to right shunt, produces a diminution or disappearance of this murmur. The same concept may be applied to the mid-diastolic rumble of atrial septal defect, which is produced by increased flow across the tricuspid valve.

B. *Atrial Systolic Murmurs: (Presystolic Murmur):* The atrial systolic murmur occurs in any condition in which there is obstruction to the flow of blood across the mitral or tricuspid valve and overloading the right or left atrium. It is one of the typical auscultatory findings in mitral or tricuspid stenosis (Figure 12a). The murmur disappears in the presence of auricular fibrillation, but may appear in right or left ventricular hypertension due to aortic stenosis, pulmonary stenosis, systemic hypertension or pulmonary hypertension from any cause (Figure 12). In the presence of heart failure, the contractions of the atria help to maintain ventricular filling. In this situation, a fourth sound, or atrial systolic murmur may be recorded (Figure 12c). The prolongation of atrioventricular conduction may facilitate or be responsible for the recording of this phenomenon (Figure 12b).

Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, 476 Prospect Street, La Jolla (Benchimol).

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Regional Isolation Perfusion in the Treatment Of Advanced Malignant Disease

HALE R. TOLLETH, *M.D.*, and JAMES D. COLT, *M.D.*, Bakersfield

• **Regional isolation perfusion with an alkylating agent was carried out in a small community hospital, using readily available equipment, ten times in nine cases of advanced malignant disease. Visible regression of tumor, either grossly or histologically, occurred in seven patients and decided subjective improvement occurred in five patients.**

The long range effect of the procedure could not be determined in the present series, not enough time having elapsed.

Side effects included jaundice in four patients, massive necrosis of the tumor in one patient, nausea and vomiting in three patients, postoperative edema in five patients, wound infection in two patients, Horner's syndrome in one patient, temporary alopecia in three patients, and depression of hemoglobin level in seven patients, of the leukocyte count in four patients and of the platelet count in four patients.

A feature of the procedure used in the present series was a system of monitoring the escape of alkylating agent into the systemic circulation.

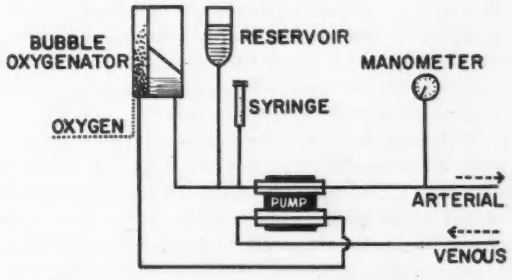
SINCE THE DESCRIPTION in 1931 by Adair and co-workers[1] of the treatment of cancer by local application of mustard compound, many investigators have sought ways to avoid the systemic toxicity of this and similar drugs. A notable advance was made by Klopp, in 1950,[5,17] when he reported that the intra-arterial injection of nitrogen mustard resulted in definite tumor necrosis. Bateman and co-workers in 1951[6] reported that nitrogen mustard was better tolerated when given intra-arterially than intravenously. They believed that obstruction of venous return from the tumor-bearing area was a significant factor in protection of the bone marrow against the effects of alkylating agents.

The original suggestion on utilization of an extracorporeal circulation to increase the dose of chemotherapeutic agents to a tumor-bearing area was made by Klopp and coworkers. Then in 1957 Creech and his associates began surgical isolation and perfusion of various regions. Many reports from this group, since the initial one in 1958,[23] have detailed the basic techniques of isolation perfusion and the early results in treatment of a variety of tumors.[9-13,21,23] Hickey,[15] Woodhall,[26] Austen,[4] Monaco[20] and Stehlin[24,25] have also reported on this method of treatment.

METHOD

Many investigators have reported the use of isolation perfusion in advanced malignant lesions but in general the reports are from large, well-equipped hospitals. The present communication is to describe a method of isolation perfusion carried out with ordinary equipment in a small community hospital, and to give a preliminary report of results obtained in ten perfusion procedures on nine patients.

Although many excellent pumps are available, we used a Sigmamotor pump that has been used as part of a Kolff double coil artificial kidney. A bubble oxygenator,* as developed initially by Hyman,[16] was incorporated into the system. Using outlet tubing† from the artificial kidney, a circuit is formed (see Figure 1) which permits positive pressure on the arterial side and a negative pressure on the venous side, an arrangement that tends to lessen the escape of the antitumor agent from the perfusion circuit into the general circulation. Additional tubing that was needed for connections was available as K-66 tube. An aneroid blood pressure manometer that may be autoclaved without damage is incorporated



EXTRACORPOREAL PERFUSION CIRCUIT

Figure 1.—Scheme of extracorporeal circulation system using Sigmamotor pump and tubing from a Kolff artificial kidney.

Resident in Surgery, Kern County General Hospital (Tolleth); Attending Staff, Kern County General Hospital and Mercy Hospital (Colt.)

Submitted December 9, 1960.

*Available as PulmoPak (Abbott).

†Available as U 200 B tubing (Travenol Labs.).

into the system, in order to monitor pressure. Intravascular catheters of several types§ have been used for vessel cannulation. We believe that the disposability of the system, except for the manometer, is an important characteristic.

When the system has been assembled and each connection wired, the tubing is flushed with normal saline solution and checked for leaks. Then it is primed with 750 cc. to 1,000 cc. of heparinized blood. Approximately 15 minutes before surgical isolation of the involved region, the patient is given heparin, 1.5 mg. per kilogram of body weight. Perfusion is then carried out for 30 to 60 minutes, the time depending on the drug being used, the region and the amount of escape into the general circulation.

When perfusion is completed, the blood containing the alkylating agent is flushed from the system with 500 cc. to 1,000 cc. of dextran. Five hundred to 1,000 cc. of blood that does not contain any antitumor drug is then returned to the isolated region. The catheters are removed, the vessels repaired and the patient given hexadimethrine (Polybrene), 2 mg. per kilogram of body weight, to counteract the previously administered heparin.

During the procedure the escape of the blood containing alkylating agent into the systemic circulation is constantly monitored in the following manner: A radioactive tracer, usually radio-iodinated serum albumin (RISA), is injected into the perfusion system. After it is thoroughly mixed, a base line level of radioactivity within a fixed area of the circuit, usually over the reservoir of the lung, is determined with a scintillation counter. It is then presumed that any loss of radioactivity from the perfusion circuit is due to escape of alkylated blood into the general circulation. With this method, the amount of escape can be quickly and accurately computed at any time and thus allow an adequate but not excessive dose of alkylating agent to be used.

Many drugs have been used in isolation perfusion. We have used three: Mechlorethamine (nitrogen mustard),* cyclophosphamide (Cytoxan)† and phenylalanine mustard (Alkeran).‡ The dosage for each area of the body has varied with the degree of isolation and the amount of escape as it was determined during the perfusion (see Table 1).

We used various rates of flow of the perfusion mixture, from 60 cc. to 250 cc. per minute, governing the rate by maintaining the pressure in the system between 85 and 300 mm. of mercury, depending upon the patient's systemic pressure. A pulsating flow was used except for perfusion of the liver; there a non-pulsatile flow was deemed more physiologic.

§Bardic & Sterilon—C. R. Bard, Inc.
*Merck, Sharpe & Dohme.
†Contributed by Mead Johnson Co.
‡Contributed by Burroughs Wellcome Co.

TABLE 1.—*Drug Dosage Used in Perfusion Therapy of Surgically Isolated Tumors*

		Mg. per Kg. of Body Weight
Head and neck	Nitrogen mustard	0.55-0.60
Breast	Nitrogen mustard	0.75
Liver	Phenylalanine mustard	1.5
Pelvis	Nitrogen mustard	1.0
	Cytoxan	11.0
Lower extremity	Phenylalanine mustard	1.6

The surgical operation that prepared the tumor site for perfusion had to isolate the region as completely as possible, yet vessels had to be preserved for adequate vascular supply to the region at the end of the procedure. The ideal plan in each area appeared to be elimination of collateral circulation so that during perfusion there would be one artery and one vein entering and leaving the isolated area through which circulation was carried out. With escape of the alkylating agent into general circulation thus partially blocked, larger doses could be used and lesser systemic defects be predicted. However, we found complete isolation to be impractical in most areas. It was almost possible in the liver and in the lower and upper extremity; least possible in the pelvis, the breast and the head and neck.

Lower extremity isolation was carried out through the transperitoneal approach. An iliac node dissection was done, not primarily for removal of metastatic nodes, but to allow complete exclusion of collateral circulation. Not all of the arteries were ligated and transected; many of the larger branches were temporarily loop-tied or cross-clamped with vascular clamps. Four main vessels that were excluded from the perfusion circuit were the iliolumbar, obturator, inferior epigastric and circumflex iliac arteries. An Esmarch bandage tourniquet was placed around the thigh in the gluteal crease and the limb was suspended anteriorly by a special frame, obliterating venous return except through the iliac vein anteriorly. The desired result was an inflow tract through only the external iliac artery and a return through the external iliac vein. The cannulae were secured in the vessels with looped umbilical tapes, and vascular clamps were placed proximally. Upon completion of the perfusion, the cannulae were removed and the incisions in the vessels closed with No. 5-0 arterial silk; loop ties were cut and removed.

Pelvic perfusion required much more dissection because of the bilateral isolation necessary in the true pelvis. The aorta and vena cava were isolated between the level of the bifurcation of the aorta and the origin of the inferior mesenteric artery. Four main branches of the hypogastric artery eliminated from the perfusion circuit were the iliolumbar, su-

TABLE 2.—*Summary of Clinical Data on Perfusion of Ten Malignant Tumors*

No.	Age	Sex	Diagnosis	Drug	Dose (Mg.)	Time (Min.)	Flow Rate (cc./min.)	Escape Rate (Per Cent)	Region Perfused	Vessels Used
1.	73	F	Liposarcoma of the thigh	P*	90	60	240	15	Leg	External iliac artery and vein
2.	48	F	Cystadenocarcinoma of ovary metastatic throughout pelvis	N†	50	45	180	22	Pelvis	Aorta and vena cava
3.	33	F	Carcinoma of cervix stage IV	C‡	500	60	155	32	Pelvis and leg	Aorta and vena cava
4.	69	F	Carcinoma of cervix stage IV	C	1000	55	130	24	Pelvis	Aorta and vena cava
5.	73	F	Liposarcoma of the thigh	P	100	65	170-200	6	Leg	External iliac artery and vein
6.	54	M	Lymphoepithelioma of nasopharynx	N	50	60	50-80	58	Head	External carotid arteries and common facial veins
7.	49	F	Carcinoma of cervix stage IV	C	1000	30	250	20	Pelvis	Aorta and vena cava
8.	34	F	Malignant melanoma of liver	P	75	60	200	2	Liver	Portal vein and hepatic veins
9.	63	F	Squamous carcinoma of breast metastatic to axilla	N	40	35	130	50	Breast and axilla	Subclavian and internal mammary arteries and veins
10.	51	M	Squamous carcinoma post. 1/3 of tongue	N	40	40	80	75	Head and neck	External carotid arteries and common facial veins

*Phenylalanine mustard. †Nitrogen mustard. ‡Cyclophosphamide.

perior gluteal, obturator and inferior gluteal arteries bilaterally. Both external iliac arteries and veins were then cross-clamped and cannulae were inserted into these vessels; perfusion was carried out, the cannulae removed and the vessels closed as before.

In perfusion of the head and neck, the external carotid artery was used. The incision extended from the angle of the jaw on one side, to the angle on the other side, crossing the midline at the level of the thyroid cartilage. Because of the rich anastomosis between the right and left side, both sides had to be included in the inflow and outflow tracts. With tumors of the nasopharynx and soft parts, the external carotid arteries were used as inflow with the superior thyroid, posterior auricular, occipital, superficial temporal and transverse facial arteries being loop-tied, and thus excluded from the perfusion circuit. Perfusion of a lesion involving the tongue required that the external maxillary, the lingual and ascending pharyngeal arteries be left in the perfusion circuit. Venous ligation included the anterior jugular, external jugular below its communications with the common facial vein, the pharyngeal tributaries to the internal jugular, the superior thyroid and lingual branches plus the superficial temporal veins. The common facial vein was used as the outflow tract. The incisions in the vessels were closed as described above.

The liver was the most difficult to isolate, owing to the physiologic and anatomical problems concomitant with such a procedure. The portal blood flow was shunted around the liver to the systemic circulation and the hepatic venous flow was used to drain the liver. By the use of a tubular shunt inside the vena cava, the blood from the lower extremities could be shunted around the liver to the heart; the portion of the vena cava into which the hepatic veins drained was cannulated for use as the outflow tract, thus preventing any blood from this organ from reaching the systemic circulation. The inflow tract used was the portal vein. The hepatic artery was excluded from the perfusion circuit by temporary cross-clamping. Because of the complexity of this procedure it will be described at length in another communication. Suffice it to say that technically the procedure is feasible but difficult.

Breast perfusion entailed a difficult dissection in view of the numerous points of anastomosis about the subclavian artery. We approached these vessels by splitting the sternum and transecting the midportion of the clavicle. The internal mammary artery was used in the perfusion circuit, while the vertebral artery was left in the general circulation. A catheter was inserted through the subclavian artery, in addition to the internal mammary, and the return was carried out through the subclavian and

TABLE 3.—*Summary of Observations on Effect of Perfusion Therapy of Surgically Isolated Malignant Lesions*

No.	Diagnosis	Previous Treatment	Postoperative Complications	Follow-Up
1.	Liposarcoma of thigh.	None. Amputation refused.	Temporary jaundice. Ileus.	Necrosis histologically and decrease in tumor size. Weight gain.
2.	Cystadenocarcinoma ovary, metastatic throughout pelvis.	X-ray to pelvis P32 injection in tumor. P32 intraperitoneal. Unsuccessful attempt at exenteration.	Massive necrosis of tumor and drainage through wound. Alopecia.	Visible regression of vaginal and labial metastases, pain relief and weight gain. Died 5 mos. postop. due to uremia. Given cyclophosphamide postop.
3.	Carcinoma of cervix stage IV.	X-ray 3600 R. Radium 5400 mg. hrs.	Persistent nausea and vomiting (preop. and postop.). Alopecia.	Severe leg and back pain preop. persisted postop. Required neurosurgical relief. Given cyclophosphamide postop. Probable inadequate drug dosage.
4.	Carcinoma of cervix stage IV	None.	None.	Mass necrosed from cervix. Pain relieved completely for 2 months. Discharge decreased, became operable.
5.	Liposarcoma of thigh.	Isolation perfusion (see Case 1).	None.	Further decrease of tumor mass. Probably operable.
6.	Lymphoepithelioma of nasopharynx.	Cobalt 60 7700 R. X-ray 8038 R.	Edema of face and neck. Wound infection. Alopecia.	Relief of intractable pain. Temporary improvement in cranial nerve palsies. Weight gain.
7.	Carcinoma of cervix stage IV (metastatic to vulva and throughout pelvis).	X-ray 2600 R. Radium 5500 mg. hrs.	Temporary jaundice. Edema of legs.	Died 19 days postop. in uremia due to ureteral obstruction. Necrosis of large vulvar metastasis present. Postmortem showed widespread metastases — liver, nodes, omentum.
8.	Malignant melanoma liver (metastatic from the eye).	None.	Died 45 minutes postop. due to cerebral anoxia.	
9.	Squamous carcinoma of breast (metastatic to axilary nodes).	None.	Edema of arm. Temporary jaundice. Temporary Horner's syndrome.	Approximately 80 per cent of tumor necrosed. Axillary metastases regressed. Given radiation and postop. injections of cyclophosphamide immediately adjacent to tumor.
10.	Squamous carcinoma of post 1/3 tongue.	Radiation—amount unknown.	Temporary jaundice. Edema of face and neck.	Died suddenly on 11th postop. day due to tracheal obstruction from inspissated mucus. Histologic evidence of tumor necrosis prior to death.

internal mammary vein. Because of the possibility of poor healing, the sternum was wired and the clavicle ends were approximated with an intermedullary pin. Healing was per primum.

RESULTS

Isolation perfusion treatment was carried out on nine patients, twice in one of them. A summary of data on the patients, the kind and site of lesion, the treatment and preliminary observations of results is given in Tables 2 and 3. In each case the tumor to be treated was considered beyond further treatment by conventional means or the patient had refused conventional treatment. The nature of the lesions varied: a very large liposarcoma of the thigh in an elderly woman who had refused amputation; a lymphoepithelioma of the nasopharynx with chronic severe pain; carcinoma of the cervix, stage IV (three cases); widespread cystadenocarcinoma of the ovary; squamous cell carcinoma in the medial quadrant of the right breast; and massive infiltration of the liver by metastatic malignant melanoma.

Demonstrable changes in the tumor either grossly or histologically were noted in all but one patient. Decided regression in size of the tumor mass or of metastatic lesions was noted in five patients. Disappearance of odor, of bleeding or of discharge of purulent material from the tumor mass was apparent in four patients. Relief of pain, however, was the major subjective improvement in three patients. An example of the changes which occur, in which gross histologic evidence of massive tumor necrosis was present, is shown in Figure 2.

The amount of alkylating agent which escaped into the systemic circulation varied from 2 per cent to 75 per cent depending on the region being perfused (see Chart 1). Hematopoietic depression, to some degree, occurred in all patients; leukopenia with a white blood count between 1,000 and 2,000 cells per cubic mm. occurred in only four patients;

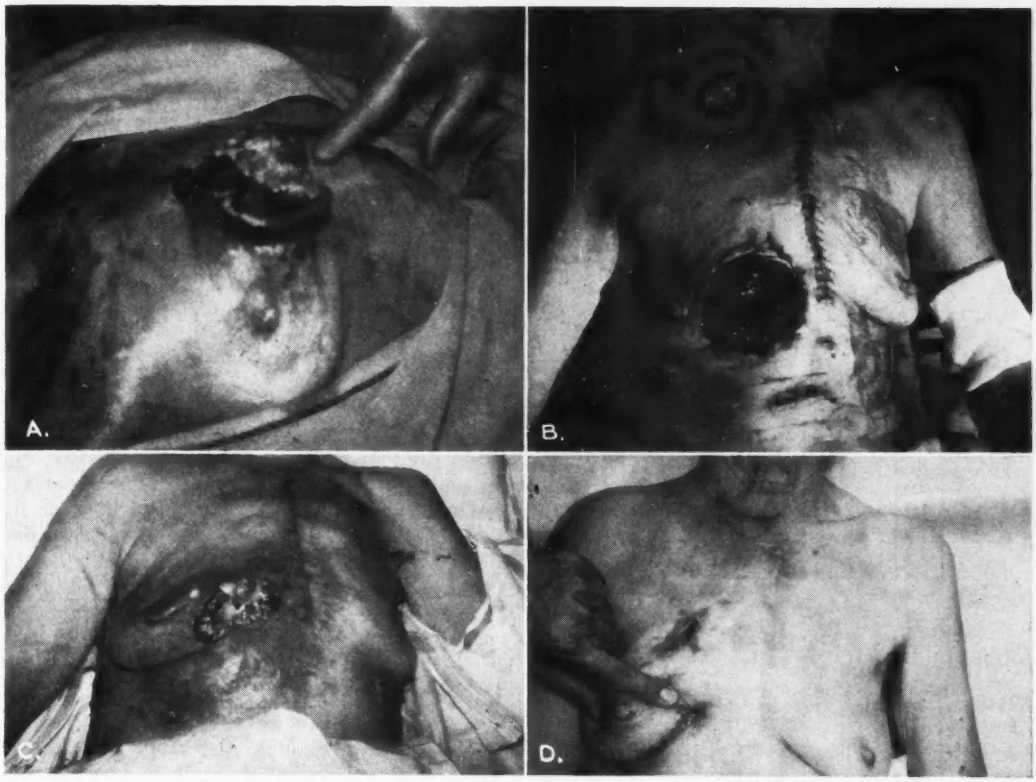


Figure 2.—*A*, ductal carcinoma of right breast before operation; *B*, 72 hours after isolation perfusion with nitrogen mustard, 40 mg.; *C*, five weeks after perfusion, the majority of the lesion having sloughed; *D*, six months after perfusion, the lesion being healed and a biopsy negative for recurrence.

the platelet count fell below 100,000 in four patients and the hemoglobin level fell below 10 grams per 100 cc. in seven patients (See Chart 2). Evidence of abnormal bleeding was not observed. Two patients had wound infection but a relationship with leukopenia was not demonstrable.

Nausea and vomiting, which often occur on the administration of alkylating agents in high dosage,[2,14,22] occurred postoperatively in three patients, one of whom had these symptoms preoperatively. Diarrhea or melena did not occur. Ileus was present in most patients but six of nine patients were taking food by mouth by the third postoperative day.

An unusual problem was present in four patients: Jaundice appeared on the second to fifth postoperative day, then disappeared spontaneously within the following four to five days. All had had liver function tests, the results indicating impairment, before operation. The icterus index did not rise above 25 units in any patient; the transaminase level was elevated in only one case. Bile and urobilinogen were irregularly present in the urine in each of the four. Although serum hepatitis was suspected in one patient, no positive diagnosis could be made. We

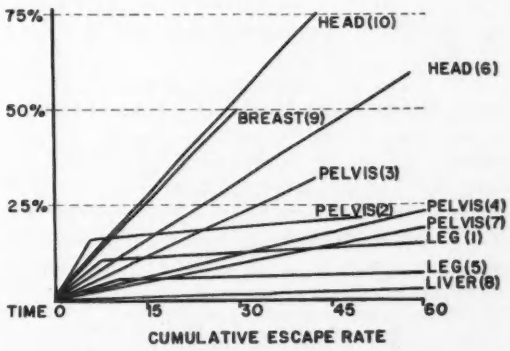


Chart 1.—Proportion of alkylating agent (shown in per cent of total) that escaped into systemic circulation in period (shown in minutes) of perfusion of lesions at various sites. The numbers in parentheses after the location of the lesions refer to the case numbers in Tables 2 and 3.

now believe that the decreased ability of the liver to handle the products of cellular destruction and hemolysis was the basic cause.

Wound infection occurred in two patients, on the 15th and 20th postoperative days respectively. One

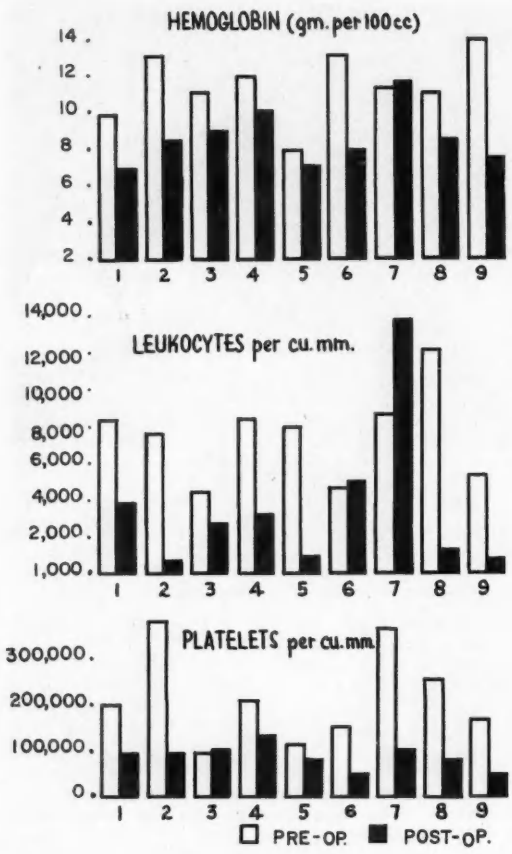


Chart 2.—Highest preoperative and lowest postoperative values for hemoglobin, leukocytes and platelets in nine patients.

had a head and neck perfusion with tracheostomy; in the other, wound dehiscence occurred. A third patient had massive discharge of necrotic material from the wound; infection, however, was not a problem. In the present series delayed wound healing did not appear to be more of a problem than is usually encountered in patients with widespread neoplastic disease and the associated problems of hypoproteinemia and general debility.

Postoperative edema, skin discoloration, erythema and necrosis have been reported in patients receiving high doses of alkylating agents by perfusion.[24] In the present series edema was moderately severe in both head and neck perfusions; in two pelvic perfusions edema of the legs, present preoperatively, became worse; and in the breast perfusion edema and pain of the upper extremity occurred postoperatively. Erythema and desquamation, similar to that of a superficial second degree burn, also occurred in the patient who had a breast perfusion.

Overloading of the circulation due to escape of fluid from the perfusion circuit into the systemic circulation, did not occur. In the liver perfusion, overloading of the systemic circuit due to overtransfusion during the surgical procedure was relieved by draining blood into the perfusion circuit.

Alopecia occurred in three patients, two of whom were given short courses of cyclophosphamide postoperatively. The hair regrew.

In this series of ten isolation perfusions on nine patients, three postoperative deaths occurred. The first patient died approximately one hour after perfusion of the liver, apparently as a result of irreversible hypotension which developed during the operation. The second died 12 days postoperatively as a result of tracheobronchial obstruction due to inspissated mucus, the tracheostomy tube having been removed prematurely. The third patient died on the 19th postoperative day in uremia due to ureteral obstruction. A fourth patient died five months postoperatively from the same cause. Both families refused to permit operative relief of the ureteral obstruction, which in each case was due to tumor. In three of the four cases, then, death could probably have been postponed at least for a short time.

DISCUSSION

Our experience with isolation perfusion operations, although incomplete and imperfect, is such as to encourage further use of the treatment. The gross and microscopic appearance of the tumors gave evidence of tumor destruction. In most of the cases, the patient was considered to have terminal disease for which conventional treatment was no longer feasible. In a few cases regression of symptoms was the most important effect; and although probably temporary, it was a development most pleasing to the patient. Whether comfortable life will be greatly extended cannot yet be determined.

While the procedure requires care, planning and meticulous postoperative observation, it is not beyond the skill of a surgeon trained in vascular procedures. The equipment is not too costly, and disposable supplies can be obtained relatively inexpensively.

The use of the scintillation counter and direct monitoring of escape of the alkylating agent into the systemic circulation seems to us superior to the method in which samples are withdrawn from the patient. Since escape may be determined very rapidly, this method allows the use of an adequate but not excessive dose of alkylating agent and prevents the serious complications of hematopoietic depression, gastrointestinal disorder, electrolyte imbalance and central nervous system toxicity as has previously been reported.[2,6,14,22]

The importance of meticulous surgical isolation and careful preoperative planning of the procedure we believe to be of considerable importance in obtaining a low escape rate.

Although perfusion of the extremities is a relatively simple procedure, areas such as the liver, breast, head and neck and pelvis require considerable more dissection. Perfusion of the liver, in the one case in which it was used was unsuccessful, but our experience led us to believe that it may be a method applicable to malignant lesions that are not successfully treated by other methods. Perfusion of cerebral lesions may offer real advantages in cases in which the tumors are relatively inoperable for anatomic reasons. The same may be true of tumors of the extra-cerebral skull and contents. Perfusion of the extremities seems to offer an excellent method for treatment of melanomas and sarcomas there, one great advantage being that amputation may be avoided.

As yet, of course, clear-cut indications for the operation and its relationships to other modes of therapy have not been well established. As a palliative measure it has appeared to us to be useful in the treatment of severe pain and other symptoms. Also, tumors previously not operable have become technically operable. At present, because of the limited number of patients and lack of comparable control, we are unable to state whether any particular alkylating agent is superior to any other in isolation perfusion procedures.

Kern County General Hospital, 1830 Flower Street, Bakersfield (Tolleth).

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Contact Lenses

The Ophthalmologist's Role in Prescription

RICHARD A. WESTSMITH, *M.D.*, San Mateo

• **It is the responsibility of ophthalmologists to determine which patients can suitably use contact lenses, to instruct them in care and use of the lenses, to write the prescription and to check the fitting, vision and tolerance of the eyes to avoid injury. This very important component of eye care should not be given over to nonmedical technicians by default.**

PATIENTS' ACCEPTANCE of corneal lenses has increased significantly in the past several years and they are used successfully by a high proportion of persons for whom they are prescribed. Contributing to this progress have been improvement of design, permitting lightness, better fitting and increased tolerance for the lenses, overcoming the "veiling" effect that once was a deterrent and, above all, the fact that the use of fluids is no longer necessary. The greatest impetus for contact lens use, however, has come from the persistent promotional campaign of advertising. A quarter of a million dollars was spent for newspaper advertising of contact lenses last year in Northern California.

Owing to general apathy by the medical profession toward contact lenses, nonmedical technicians have practically taken over this phase of eye care. It is only within the last year or so that California has required a license to fit corneal lenses, and this is not retroactive to include persons who were already fitting them when the law was passed. It is estimated that contact lenses are being prescribed at a rate of about a million per year, and that only 15 to 20 per cent of them are being fitted by physicians.

Not only have ophthalmologists in general been disinterested in corneal lenses, many have actively aspersed them.

What are the reasons for this resistance by physicians? My confreres tell me of several. (1) They are afraid of eye injury. And yet I have observed patients who have worn corneal lenses for six or seven years without any evidence of injury to the cornea and I know of no reported case of permanent damage from the wearing of a contact lens. (2) They believe that too high a number of patients cannot tolerate contact lenses. Yet a recent review showed that over 90 per cent of persons fitted with contact lenses who answered a questionnaire said they were wearing them most of the working day. (3) Some ophthalmologists feel that they may lessen their professional standing by prescribing lenses that are promoted, championed—and oversold—by technicians. Some ophthalmologists are just too busy to take on more chores with doubtful promise. The attitude reflected in these views has the effect of depriving many patients of the real benefits that may be achieved only with corneal lenses.

It seems that ophthalmology must accept the fact that contact lenses are here to stay, that they can be very rewarding to patients, and that it is the responsibility of the ophthalmologist to supervise the fitting and prevent harm to the eye. Further research by the medical profession will result in added improvements.

Ophthalmologists should be aware that in addition to the cosmetic gains of corneal lenses, there are many medical reasons for their being prescribed.

1. In keratoconus, superior vision may be achieved with contact lenses, and the progress of the disease may well be retarded or halted by use of them.

2. In cases of severe refractive errors, such as astigmatism and high myopia, much better vision may be possible with corneal lenses.

3. In persons with high degrees of anisometropia, a real binocular comfort may be achieved for the first time. The possibility of using both eyes together after a monocular cataract extraction has changed much of our thinking about advising such one sided operation. Now there is a real visual reward for such a procedure.

4. Paralytic keratitis is reported to be benefited by the use of protective contact lenses.

5. In patients with subnormal vision, due to corneal scarring, corneal dystrophy, albinism, aniridia and nystagmus, vision may be greatly benefited.

6. The correction of presbyopia by under-correcting the myopia or over-correcting the hypermetropia monocularly has been useful in selected cases. I have been gratified by this arrangement for my own eyes for the past three years. I have worn a +175 corneal

Presented as part of a discussion on Contact Lenses given before the Section on Eye at the 89th Annual Session of the California Medical Association, Los Angeles, February 21 to 24, 1960.

lens on my left eye for reading, and used my unaided right eye for distance. Contact bifocals have been disappointing to me, although such a development seems like a natural evolution.

7. Patients with allergic sensitivity to the material used in making spectacle frames, or with other facial dermatitis, may get great relief by the use of corneal lenses in place of regular glasses.

8. Some patients with low degrees of muscle imbalance have been helped enough by corneal lenses to permit them to abandon corrective prisms. Since the lenses have no prism effect, it is probable that this astonishing phenomenon is due to the fact that corneal lenses remove peripheral astigmatism, thereby helping peripheral fusion, which in turn reinforces central fusion.

Ophthalmologists should be aware of some contraindications to the use of contact lenses. It is probably wrong to prescribe contact lenses for patients who have recurrent erosion of the cornea or history of symptoms suggesting this diagnosis, or for those with a pterygium or a fleshy pingueculum that is encroaching on the corneal margin, or chronic blepharo-conjunctivitis, active keratitis or allergic conjunctivitis. In general, patients with a bad tremor or a mental problem or moderate nervousness should not have contact lenses. Another group is made up of patients who, lacking motivation or real reward from their use, probably would not be benefited enough to justify contact lenses. In my experience, patients who do not feel a need for conventional eyeglasses most of their waking hours, or who are not convinced that contact lenses would please them, should not be persuaded to try them. Also, I have avoided prescribing contact lenses for children unless they have demonstrated unusual stability and judgment and respect for personal property, but there is a report in the literature of a 7-year-old child who was fitted with a contact lens for monocular aphakia.

The claim that contact lenses arrest or retard the progress of myopia is unfounded. Usually the myopia has ceased to progress anyway by the time these lenses are fitted. In most cases of near-sightedness axial lengthening is the cause of increasing myopia, and the wearing of a corneal lens can have no effect on the process. In some patients with a low degree of myopia, however, increments in myopia may be due to increases in the corneal curvature. This increase may be corrected by wearing a contact lens, which serves in lieu of the corneal face as a refracting surface. When the lens is removed, however, the corneal face returns to its increased curvature, and an additional minus correction is needed.

Certain advice should be given patients who are about to get contact lenses. One thing is that after a few hours of wearing contact lenses they will not be able to see as well with their conventional glasses as they had before. This is a temporary change, depending upon how long the lenses were worn, and is due to a change in the corneal curvature. (It takes about 72 hours for my own K reading* and visual acuity to return to normal.) Another thing that patients should be told is that contact lenses should take the place of regular lenses for most uses, for not many will achieve comfort if they wear their contact lenses irregularly or infrequently. Advising about cleanliness is of utmost importance. Hands should be washed well with soap and water before the lenses are handled, and one must avoid touching the lens with grease, oil or cosmetics. If the lens is exposed to greases, it may be cleaned with lighter fluid, washed well with soap and water and placed in a soaking solution for several hours. When the lenses are removed from the eyes, they should be washed well with water and immersed in a container of the solution. As the plastic material of which lenses are made is wetted with great difficulty, a wetting agent must be used to increase the wetness of the surface. Although saliva is an excellent wetting agent, using it must be forbidden because of its contaminants. When the patient is learning to wear contact lenses, he should not increase the wearing time each day by more than a half hour over the time they were worn the previous day. I have observed several cases in which corneal abrasions resulted from over-zealous early wearing before tolerance was achieved. In such cases, pain does not develop until several hours after the lenses have been removed, owing to a reduction in corneal sensitivity induced by wearing the lenses. The patient should be instructed to return to the ophthalmologist for observation after wearing the lenses for four hours. At this time the vision is examined but the prescription is not changed, unless it is grossly in error. The fit of the lenses should be determined by instilling fluorescein and viewing the eyes with a slit lamp under a cobalt blue light. A central pooling of fluorescein, or the presence of air trapped beneath the lens, indicates the curvature of the corneal lens is too sharp. Too little fluorescein beneath the lens indicates it is too flat. A flat lens tends to abrade the cornea and to slide off position very easily. Any surface abrasions of the cornea should be noted and the technician who prepares the lenses should be advised as to the observation. The patient should be seen again in two weeks for further observation, and at this time, if the lens is settled well against the cornea, mild changes in the prescription may be made to improve vision. The patient should then be observed at monthly intervals for the next four months.

12 North El Camino Real, San Mateo.

*Keratometer reading of flattest corneal curvature.

Cerebral Palsy

Diagnosis in Young Children

MARGARET HOLDEN JONES, *M.D.*, Los Angeles

• **Definite diagnosis of cerebral palsy is usually possible during the first six months of life in the hemiplegic child, but in the paraplegic or quadriplegic it may not be clear until the second half of the first year or later. Diagnosis should include not only type, degree and extent of motor handicap, but also intelligence, personality factors, sensory deficits, seizures and other physical problems.**

Diagnosis depends on detecting deviations from normal growth and development, of being aware of a multitude of progressive and other lesions which may simulate, at least early, the "static" group of conditions characterized by motor deficit due to central nervous system disease.

Management involves early positioning, use of special equipment (mainly improvised), sensory stimulation and experience, as well as motor training, evaluation of intelligence and special learning situations to assist in discrimination learning and lengthening of attention span. Nursery schools for mentally capable children from 18 months to 3 years of age assist in developing independence, maturity and growth of personality. Except for patients with very severe mental or physical involvement, competitive employment in adult life is not related so much to the physical handicap as to personality characteristics, traits which are formed in early years.

EARLY DIAGNOSIS of motor handicap due to central nervous system abnormality is particularly important today for two reasons. First, we are gradually acquiring more specific tools for identifying metabolic, endocrine and other conditions early, which in some instances may lead to definitive treatment. Second, as cerebral palsied children grow up, we learn that success in achieving their maximal potential depends almost more on personality development than on overcoming the physical handicap. Therefore, consideration of personality development is as important as training for motor skill.

Cerebral palsy, by definition, includes a group of conditions with a motor handicap due to central nervous system lesions of a nonprogressive nature.

In order to differentiate such lesions of the central nervous system from the many other causes of abnormal motor development, it is important to know whether the child was "normal" for any period after birth. Thus, use of scales of growth and development is essential for purposes of detecting uneven growth patterns. It is helpful to differentiate progress in several areas rather than to give a global estimate of level of achievement. From scales such as those of Gesell,[11,25] Griffiths,[12] Watson and Lowry[31] or Shirley[9] the physician should select one that he prefers and should become so familiar with it that he can readily rate infants as to locomotion, hand use, speech and personal-social development. Some years ago, at the Children's Hospital in Los Angeles, with the assistance of Dr. Russell Sands, the staff of the Cerebral Palsy Diagnostic and Treatment Clinic compiled a simple outline based mainly on the Gesell scales.[18] This was found useful in quick evaluation of developmental level. The scales thus compiled are reproduced at the end of this article. Data from such scales or others in which developmental status can be related to chronological age were then entered on a chart whose abscissa was age and whose ordinates were factors of physical development related to age and of achievements also related to age. These included locomotion, self-help, speech, personal-social development, mental age and Vineland Social Maturity rating.[8] Chart 1 is an example of this kind of chart. If the child's development in all areas is at age level, the data will fall on a horizontal line. The data recorded in Chart 1 show average height, weight and head size for age but pronounced retardation in locomotion and speech, although normal mentality. This uneven development is frequently seen in cerebral palsy.

The following outline is suggested for a minimal neurological examination of the newborn. In the order outlined it can be carried out quickly and with minimal handling of the infant.

Suggested Procedure for Neonatal Examination

Position of Child	Examination
Supine:	Asymmetry—head, face, palpebral fissure.
	Spontaneous activity—head, face, trunk, extremities.
	Vision—blink, eye following, pupils, lens.
	Auropalpebral reflex or startle to loud noise.

Presented before the Section on Pediatrics at the 89th Annual Session of the California Medical Association, Los Angeles, February 21 to 24, 1960.

Rooting-sucking reflex.
Grasp—palmar, toe.
Patella reflex—ankle clonus.
Traction response—(head lag on pulling forward by arms).
Moro (note asymmetry and completeness).

Upright: Stepping—body in slight forward flexion.
Placing—dorsum of foot under table edge, child places foot on top of table.

Prone: Neonatal head turning.

It is important to note on the record also:

1. Conditions during examination, and time of day, as well as date.

2. General muscle tone.

3. Anomalies or congenital malformations or skin defects.

Thomas and Dargassies[28] stressed the need of repeated neurological examinations in the newborn if any abnormality is noted, for change is particularly significant—for example, change in the Moro response, such as disappearance of the response after it has once been obtained in the newborn, which is a phenomenon that may occur with increasing intracranial pressure.

Some transitory postural and righting reflexes and the normal ages at which they are found are:[7]

Transitory Reflexes

Moro	3 months
Rooting and sucking	12 months
Grasp, palm	3 to 4 months
Grasp, toe	9 to 11 months
Asymmetrical tonic, neck	3 to 6 months
Landau	10 to 28 months
Tongue retrusion	One month, more or less
Stepping	2 to 7 months

Ingram suggested that maturation of neuromuscular development is slower and may cease at a relatively primitive stage in cerebral palsied children.[17]

If delay in development or persistence of transitory reflexes beyond the normal period is noted, there are many conditions[7] to be differentiated before management is planned on the basis of a "static" type of central nervous system lesion.

Ten general kinds of conditions to be considered in differential diagnosis in cases of delayed motor development are:

Mental retardation.
Metabolic and endocrine defects.
Progressive degeneration of central nervous system.
Infectious disease (subacute or chronic).
Neurocutaneous lesion with associated central nervous system abnormality.
Dysrhaphic states—abnormality of skull or spine.
Cord and spinal injuries.
Tumors and other intracranial lesions.
Primary muscle disease.
Emotional or behavior problems.

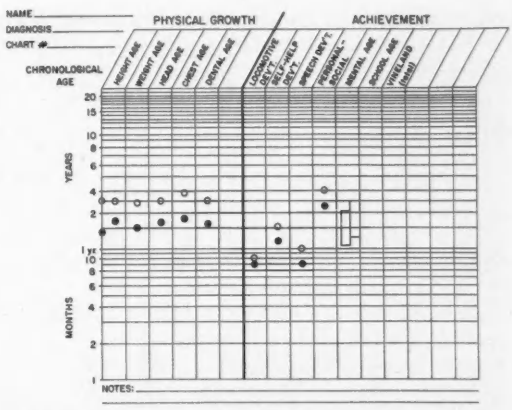

Chart 1.—Summary chart of growth and achievement.

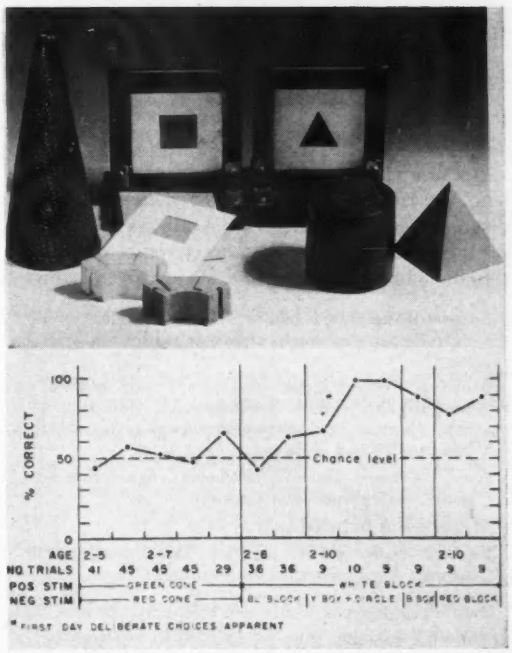

Figure 1.—Objects used for discrimination learning. Below, chart of results of discrimination learning trials.

Once diagnosis of a nonprogressive lesion is made, particularly if it is severe in degree, it is important to evaluate vision and hearing before attempting to assess intelligence. This often means observation in a relaxed situation, as in a nursery for cerebral palsied children, in addition to the office evaluation. In some children there is a constant delay of seconds following a question. One must wait for a response rather than going quickly from question to question.

It is possible to estimate speech reception level by the use of special scales even if no speech has been achieved.[6]

Evaluation of psychometric test-retest results in children from a year and a half to three years of age indicates good reliability.[21,32] Testing of a nonverbal child's understanding is most difficult. Preliminary studies in 2-year-olds without speech indicate discrimination learning ability after a rather extensive period of training.[1] Objects used for this training (Figure 1) are of varied colors, shapes and forms. Each has a hollow base under which a reward is placed. As noted in the graph beneath the picture, at the start of testing the child could not make the right choice simply on the basis of a difference in color between the otherwise similar objects, but after a series of choices of one of two decidedly disparate objects, this child was then able to choose by color alone.

In a severely physically retarded child, hypotonia may later change to hypertonia if cerebral palsy is of the spastic type. In athetoid conditions, muscle tension and athetoid movements become evident after the second or third year of life.[16]

Because management varies with the motor problem, the clinical type of motor deficit should be determined, although it is not always possible to do this in early infancy. Characteristics of each of the commonly differentiated types are given below:[14]

Spastic—Exaggerated patella jerk, ankle clonus; adductor spasm of hips; clenched hand after 2 to 3 months.

Athetoid—Delayed motor development early, especially head holding; persistent asymmetrical tonic neck reflex; characteristic athetoid movements may be delayed until 3 to 4 years.

Ataxic—Delayed motor development; hypotonia; terminal ataxia, hand—4 to 5 months.

Tremor—May be found early.

Rigidity—Stiffness after first few days; patella jerks normal; grossly retarded development.

Some clinical correlates are frequently found, and knowledge of them may be helpful in evaluating the clinical types of motor deficit in the young infant.[24]

Clinical Correlates

Prematurity—Spastic paraplegia (often observed after 6 months).

Hyperbilirubinemia—Athetosis (often with deafness and poor vertical eye control).

Severe anoxia at birth—Athetosis.

Sensory testing of the infant involves more than response to pinprick. However, if a pin is used, the type of response can offer a clue to developmental age. McGraw[22] observed the following reactions in a series of normal infants:

Figure 2.—Child in posture trainer jacket with overhead four point suspension on movable frame. The jacket is similar to jumper swing, fits snugly as a corset and extends almost to axillae. The anterior and posterior rings of the harness can be tied together over the shoulders and this strap attached to the back of an ordinary chair to promote good sitting position and security in sitting.

Newborn or diffuse response	to 1 month
Inhibition of the diffuse response	1 to 3 months
General localization (deliberate withdrawal)	6 to 13 months
Specific localization	8 months on

In addition to pinprick testing, much more information can be gained, especially in hemiplegics, by observing reaction to light touch (feather, cotton or brush), by noting appreciation of a small object, such as a pencil or penny, placed first in the affected hand, then in the other, and by the response to passive movement of fingers and hand.[20]

Tizard and coworkers[29] demonstrated that sensory deficit is directly related to skeletal undergrowth (length) of the extremity. Of 16 hemiplegics with skeletal undergrowth, 14 had sensory deficit and hemianopsia; conversely, of 12 with no growth deficit, only two had sensory loss and hemianopsia.

Tachdjian and Minear[27] reported an inverse ratio of sensory loss and functional use of the extremity in hemiplegic patients. Among those with no use of the hands, 87.5 per cent had sensory loss, while 6.6 per cent of patients with good use of the hands had sensory loss.

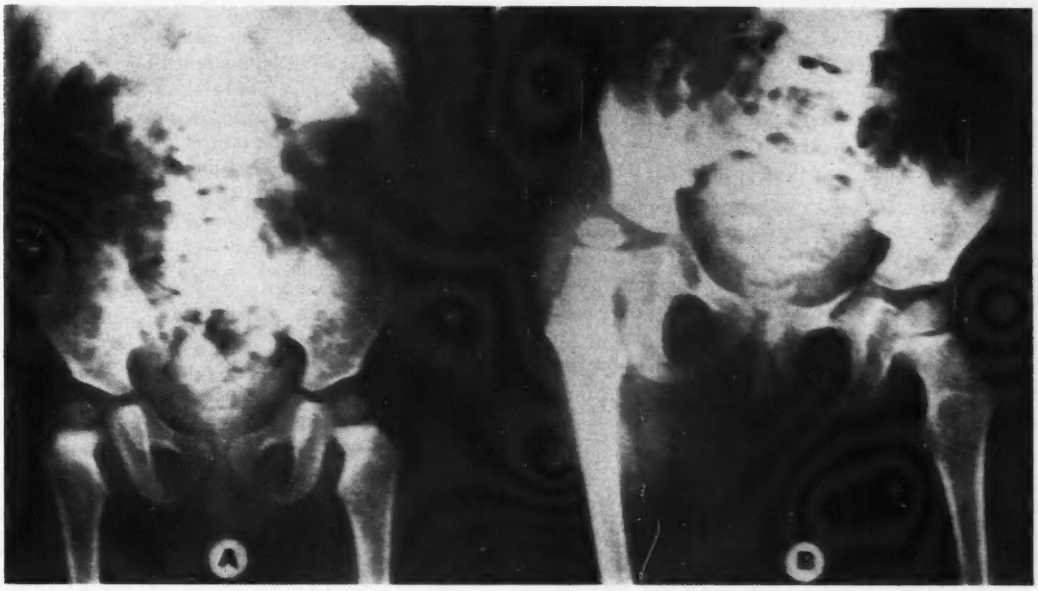

Figure 3.—X-ray films of pelvis to show migration of femoral head. Tension athetoid cerebral palsy with subluxed right femoral head *A*, at age 1 year; *B*, at age 3½ years. Note: Valgus of femoral neck on right, 165°. Acetabular index normal.

MANAGEMENT OF YOUNG PALSIED CHILDREN

Management of a cerebral palsied child under three years of age involves parent cooperation in working toward maximal independence within the capability of the particular child. He must be provided with opportunity for sensory and social experiences, as well as training in motor skills. Understanding of his psychological problems, and assistance with solving them, are needed. Special facilities are needed for him at home, and in some instances at nursery school. Because of the persistence of postural and righting reflexes beyond the normal time, positioning of the cerebral palsied infant to help overcome these reflexes and to allow the baby to experience normal patterns of motion for age is suggested.[3] Such positioning can be taught to the parent and carried out at home.

A posture jacket[19] or a jump swing (Figure 2) may allow practice in head balance and better arm and hand use, as well as promote intercostal breathing by allowing the child to be in an upright position. The anterior and posterior rings of the harness can be tied together over the shoulders and this strap attached to the back of an ordinary chair to promote good sitting position and security in sitting. Because the motor deficit prevents normal exploration of the environment, sensory stimulation and experience need to be carefully planned for the toddler age child.

Treatment for cerebral palsy of the spastic type includes promotion of full range of motion and prevention of contractures. Braces may be needed. Training may also involve sensory stimulation if sensory deficit is present.

In athetoid patients, overcoming of persistent postural and righting reflexes, relaxation and muscle strengthening may be needed.

In ataxic children, balance training and often muscle strengthening are helpful if the condition is severe; if mild, and the child has normal eye movements, balance will tend to develop spontaneously.

It is particularly important to evaluate various types of sensory as well as motor abnormality, and also to consider intelligence, seizures and personality factors, before making a treatment plan for a palsied child.[2] Personality characteristics, particularly immaturity and dependence, have been found to be major factors in failure or success in adult life. At least half of cerebral palsied patients have a significant learning deficit.

Care at home of a severely physically retarded infant is difficult and obviously will become more so as the child becomes older and heavier. One must remember, however, that in a child of this type fever often develops without demonstrable cause when the child is placed in a hospital or other institution. Although self-sufficiency or competitive employment

is not to be expected of severely physically retarded children, some of those with good intelligence may become partially self sufficient and do simple tasks, particularly if adaptive equipment can be improvised to help them—for example, a resistance feeder[13] or a special electric typewriter.[30]

Nursery schools for alert cerebral palsied children from one and a half to three years of age have been developed to offer an opportunity for socialization, for beginning independence and for integration of physical, occupational and speech therapy in the activities of everyday living. Trained nursery school teachers are responsible for the programs in the nursery schools. Therapists work closely with the teacher, often in the classroom. By observing their own and other children in the nursery school setting, parents can see their child in a more objective way.

Orthopedic consultation is needed for braces. Surgical treatment may be essential, especially if contractures leading to deformities develop. Unequal muscle pull about a joint, particularly the hip, may result in migration of the femoral head[23] (Figure 3).

Drugs have been reported to aid in relaxation, especially meprobamate[5] and N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate (Soma®).[26] Dextroamphetamine[4] often quiets a hyperactive child. Chloral hydrate, with a small dose of chlorpromazine, 5 to 10 mg., often provides satisfactory short-term sedation, such as might be needed for an electroencephalogram.

U.C.L.A. Medical Center, Los Angeles 24.

APPRAISAL SCALES

FROM: *Appraisal of Progress in the Cerebral Palsied Child, United Cerebral Palsy Association of Los Angeles County, November 1952 (Ref. No. 18).*

SCALE 1.—Locomotive Development*

4 weeks—Prone position—lifts head momentarily.
16 weeks—Sits with back support—holds head erect.
24 weeks—Rolls over (either way).
28 weeks—Sits in high chair (not in special chair)—with or without braces—not tied in.
32 weeks—Progresses on floor (on abdomen or back).
36 weeks—Sits alone (includes getting to sitting) on floor, low mat or stool.
40 weeks—Stands holding on (if put in that position). Creeps on hands and knees—abdomen off floor.
52 weeks—Walking with one hand support.
15 months—Stands alone (includes getting up from sitting and sitting again).
18 months—Walks alone (includes stepping and starting with or without canes or crutches—not walker).
2 years—Walks downstairs holding rail. Runs 50 feet without falling.
2½ years—Jumps 2 feet.
3 years—Climbs stairs, alternate feet, no assistance. One foot momentary balance—eyes open.
4 years—Skips on one foot (either one or both).
5 years—Skips alternately.
6 years—Jumps from 12-inch step without losing balance. Stands on alternate feet, eyes closed. Climbs.

Note: Since we agree with those at the Hartwell Clinic, Rochester, New York, that "a normal six-year-old has all the motor abilities necessary for physical independence and for future economic independence," we have considered the older child adequate in locomotor development if he is able to reach this level.

*Star indicates success achieved if accomplished only with braces on.

SCALE 2.—Self-Help Development

4 weeks—Brief eye following.
16 weeks—Holds rattle when placed in hand. Momentary passive regard.
24 weeks—Eyes follow objects. Crude grasping.
28 weeks—Bilateral grasping—shakes rattle—grasps one inch cube.
32 weeks—Extends one arm in reaching.
36 weeks—Grasps with whole hand.
40 weeks—Hand feeding—pat-a-cake.
Reach and grasp for near objects.
Picks up ¼-inch pellet with thumb and opposing finger.
52 weeks—Picks up spoon.
Takes off some clothes—cooperates in dressing.
15 months—Puts on simple clothes.
Puts ¼-inch pellet in bottles with 2-inch opening—without assistance.
18 months—Builds tower of 3 one-inch cubes.
Scribbles—imitates vertical stroke.
Holds glass or cup with two hands—begins to feed self with spoon.
2 years—Turns singly 4 out of 6 thick pages of child's book.
Holds glass or cup with one hand.
Builds tower of 6 one-inch cubes.
2½ years—Helps dress and undress.
Holds regular-sized crayon with finger grip.
Builds tower of 8 cubes.
3 years—Feeds self with little spilling.
Removes pants—unbuttons front and side buttons.
4 years—Drawing—some attention to details.
Brush teeth with little assistance and wash face alone.
Dress, undress with little assistance.
Cares for self at toilet.
5 years—Laces shoes and ties bow knot.
Print some capital letters.
Drawing—color outline picture.
Handedness well-established.
6 years—Uses table knife for spreading.
Winds two yards light wool yarn on wooden spool in 15 seconds (spool 1½ inches long and one-inch in diameter not including raised edges at ends of spool).
Places 45 pegs in board in 45 seconds (pegs, metal ⅛ inch by 2 inches—holes ¾ inches apart—pegs placed in deep saucer at start).

7 years—Washes self fairly completely.
Uses knife for cutting.
Combs or brushes hair.
Can bat ball three times out of five.
8 years—Bathes self unaided.
Uses fork and spoon pronatedly.
Uses tools or utensils in helpful household tasks, as fastening hook, nailing or screwing.
9 years—Cares for self at table.
Penmanship smaller and with less pressure.
Lifts heavy object, as 10 lb. bag, carries it 15 feet.
Plays ping pong—returning served ball 2 times in succession.
10 years—Pays attention to grooming (especially girls).
Writes occasional short letters.
11 years—Does simple creative work.
12-15 years—Exercises complete care of dress.

Note: Since the Vineland Scale has no self-help items in dressing, eating or general self-help over the age of 15 years, we will consider that this level of achievement is satisfactory for adult self-help and independence.

SCALE 3.—*Speech Development*

4 weeks—Small throaty sounds.
16 weeks—Coos and laughs aloud.
24 weeks—Spontaneous vocalization.
28 weeks—M-M sound—crying—squeals.
32 weeks—Single syllable—Da—Ba—Ka.
36 weeks—Imitates sound.
40 weeks—DADA—MAMA—Plus one word.
52 weeks—DADA—MAMA—Plus two words.
15 months—Four to six words.
18 months—Ten words—jargon.
2 years—Joins two and three words.
2½ years—Repetition of phrases and pronouns.
3 years—Sentences.
4 years—Sounds mastered—b, p, m, w, h.
5 years—Sounds mastered—d, t, n, g, k, ng, y.
6 years—Sounds mastered—f.
7 years—Mastery of v, th, zh, sh, l.
8 years—Mastery of z, s, r, wh, th (unvoiced).

Note: Since this level of achievement is considered adequate for oral communication both for child and adult, the older age groups are considered normal in speech if they have reached this level.

SCALE 4.—*Personal-Social Development*

4 weeks—Fleeting facial responses (brightens or darkens) to social approach.
16 weeks—Laughs aloud, "recognizes" mother. Relishes sitting position.
24 weeks—Discriminates strangers.
28 weeks—Concentrates on single toy.
32 weeks—Bites and chews toys.
36 weeks—Holds own bottle or feeds self cookie or cracker.
40 weeks—Nursery tricks—pat-a-cake.
52 weeks—Imitates or repeats performance laughed at. Influences emotions of others.
15 months—Recognizes own product of elimination after the act.
18 months—Resistant to changes and sudden transition. Pretends to read. Toilet trained for bowel control. Likes to pull toys. Carries or brings doll.
2 years—Distinguishes "mine" and "me." May fetch and carry. Pulls on simple garment.
3 years—Bargains. Tries to please. Begins to wait his turn. Shares toys.
4 years—Likes associative group play better than parallel. Alibis. Fabricates. Bosses. Goes about neighborhood unattended.
5 years—Knows own name. Likes to finish things started. Favorite toys: tricycle, crayon, scissors.
6 years—Begins exploration of outside social world. Is influenced by boy or girl down the street.
7 years—Finds heroes outside the family. Tells time to ¼ hour. Participates in pre-adolescent play (Vineland Scale).
8 years—Reads on own initiative. Does routine household tasks. Prefer same sex as companions.
9 years—Makes minor purchases. Emergence into gang groups.
10 years—Answers ads—purchases by mail. Does small remunerative work. Makes telephone calls. Identifies self with specific gang—may be leader of group.
11 years—Enjoys books, newspapers, magazines. Is left to care for self and others.
12-15 years—Plays difficult games (Vineland). Performs responsible routine chores. Engages in adolescent group activities (Vineland).
15-18 years—Communicates by letter. Follows current events. Goes to nearby places alone. Goes out unsupervised in daytime. Has own spending money and buys all own clothes.
18-21 years—Goes to distant points alone. Looks after own health. Has a job or continued schooling. Goes out nights unrestricted. Controls own major expenditures. Assumes personal responsibility.

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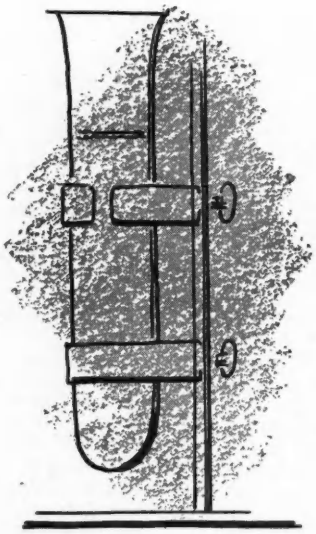

Nasopharyngeal Cancer

Five-Year Results of Treatment with Intracavitary Cobalt^{60}

JEROME M. VAETH, *M.D.*, and FRANZ BUSCHKE, *M.D.*, San Francisco

• **Seven of twenty-two patients treated with intracavitary Co^{60} therapy for nasopharyngeal neoplasms remained controlled for more than five years.**

No patient treated with intracavitary Co^{60} therapy alone has remained alive.

Of the seven surviving patients, four received external irradiation in conjunction with intracavitary therapy in doses which in themselves may well have controlled the disease, and the contribution of the intracavitary therapy cannot be assessed.

Of ten patients treated for disease, recurrent or uncontrolled, following external irradiation, intracavitary therapy was effective for control of the disease for five years in two patients. One of these patients has no demonstrable disease ten years after the last treatment. The other is alive but with recurrent local disease nine years and eight months after the last treatment.

Analysis of the material agreed with the long established experience that intracavitary irradiation for nasopharyngeal tumors is occasionally helpful in the treatment of limited mucosal recurrence or as an adjunct complementing medium-volt external irradiation. For the definitive treatment of untreated nasopharyngeal neoplasms, reliance in control is placed on thorough external irradiation of nasopharynx and regional lymphatics.

THE RECORDS OF PATIENTS with nasopharyngeal tumors treated at the University of California Hospital, San Francisco, from 1932 to 1955 were recently reviewed in detail.[4] Included in this group were 22 patients treated between 1947 and 1955 by intracavitary Co^{60} following intranasal septectomy and electrodesiccation. For details of the technique, we refer to Morrison's description in 1951,[2] and to the publications of Sooy[3] and Deatsch[1] in 1956. Since this technique, with its emphasis on intracavitary treatment, is in principle at variance with the more commonly accepted procedures which stress external irradiation, a brief presentation of the now available long term results in this small group seems of interest (Table 1).

RESULTS

Four patients were treated by intracavitary Co^{60} to the nasopharynx only (without external irradiation to either nasopharynx or regional lymphatics): In one case the lesion was melanoma, in one lymphoepithelioma, in one anaplastic epidermoid and in one epidermoid carcinoma—the latter three with unilateral adenopathy. All died of uncontrolled disease of the nasopharynx.

Of seven patients treated by a combination of external irradiation and intracavitary Co^{60}, four remained symptom-free more than five years: Three with "transitional cell carcinomas" (two with unilateral adenopathy, one with sixth nerve paralysis) and one with lymphosarcoma without adenopathy. All four survivors had received external irradiation with doses to the nasopharynx and lymph nodes in excess of 4,000 roentgens. The patient who had cranial nerve involvement at the time of treatment had recurrent nasopharyngeal tumor ten years after therapy.

Of ten patients in whom septectomy, cauterization and intracavitary Co^{60} were administered because of obvious recurrent or residual disease at the primary site, two survived more than five years without further recurrent or progressive disease. One of these two survivors, a patient with lymphoepithelioma, originally without lymphadenopathy, was first treated with external roentgenotherapy, a tumor dose of 4,000 r in four weeks. Fourteen months later, recurrence developed at the primary site which was treated with intracavitary cobalt (5,000 r) and electrodesiccation. After another six months it recurred again. Retreatment with intracavitary Co^{60}, 4,000 r, led to control of the nasopharyngeal disease to date (ten years since last treatment). The second patient, with transitional cell carcinoma, was treated with external roentgenotherapy and seven months later presented recurrent disease. Electrodesiccation, septectomy, and intracavitary Co^{60}, 6,000 r, resulted in control of this patient's recurrence for nine years and eight months. At this time recurrence developed again at the primary site. The patient is alive now, three months since the appearance of this recurrence.

One patient with lymphoepithelioma who was treated with external medium voltage radiation to the nasopharynx (estimated dose: 2,500 r in six

Presented before the Section on Radiology at the 89th Annual Session of the California Medical Association, Los Angeles, February 21 to 24, 1960.

From the Department of Radiology, University of California School of Medicine, San Francisco.

TABLE 1.—*Five-Year Results of Intracavitary Cobalt^{60} in Nasopharyngeal Cancer*

	No. of Patients	No. of 5-Year Survivors	
1. Intracavitary Co^{60} alone to nasopharynx.	4	0	All died of nasopharyngeal disease.
2. Intracavitary Co^{60} combined with external irradiation.	7	4	3 survived; free of disease. 1 alive 10 years later with recurrence.
3. Intracavitary Co^{60} alone for local recurrence.	10	2	1 lymphoepithelioma. After initial x-ray 4,000 r tumor dose, recurrent 16 months (Co^{60}, 5,000 r) and 19 months (Co^{60}, 4,000 r). Patient well today, 10 years after last treatment. 1 transitional cell carcinoma. After initial x-ray 4,000 r tumor dose recurrent at 7 months (Co^{60}, 6,000 r). Patient alive but with recurrence 9 years 8 months after Co^{60} treatment.
4. Intracavitary Co^{60} combined with external roentgen therapy for local recurrence.	1	1	1 died 7½ years after initial roentgen therapy 2,500 r tumor dose (4 years after retreatment of recurrence, Co^{60}).

weeks), returned three years later with local recurrence. He was retreated by two intracavitary applications of Co^{60}, followed by 250 kilovolt external irradiation to the nasopharynx (estimated dose mid-nasopharynx: 6,000 r in four weeks). The disease remained controlled temporarily but recurred locally four years after the retreatment, or seven and a half years after the first course of roentgenotherapy.

DISCUSSION

From review of this material, it would appear that intracavitary nasopharyngeal irradiation with Co^{60} has controlled locally recurring or uncontrolled disease following external irradiation in one instance. In four cases of survival following combined external and intracavitary treatment, it is possible that Co^{60} contributed to the results by increasing the local dose. Its role cannot be assessed, however, because in these cases external irradiation possibly would have been sufficient for local control.

When using medium-volt therapy it is at times difficult to introduce an adequate dose into the nasopharynx because about 25 per cent of the energy is absorbed in bone. Particularly in the treatment of the more differentiated tumors, we have, therefore, for many years complemented external irradiation by intracavitary radium application in selected cases, without difficulty and without preceding septectomy. Intracavitary therapy has the obvious disadvantage of delivering a very high dose to the mucous membranes with the subsequent permanent sequela of mucosal damage (mucosal atrophy, crust formation and the risk of bone necrosis) but it does not reach the extension of the disease into the immediately surrounding structures. With the use of higher voltages, such complementary procedure has become unnecessary because bone absorption is about equivalent to the absorption of soft tissues, and adequate external irradiation is therefore easily accomplished.

Department of Radiology, University of California Medical Center, San Francisco 22 (Vaeth).

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Intestinal Atresia or Stenosis in the Newborn

Associated With Fibrocystic Disease of the Pancreas

GEORGE N. DONNELL, M.D., and ROBERT S. CLELAND, M.D., Los Angeles

• In a review of cases of intestinal atresia or stenosis in the newborn at Children's Hospital of Los Angeles it was noted that in approximately 10 per cent there was clinical or anatomic evidence of fibrocystic disease of the pancreas. Histologic sections of the bowel in all these cases showed the alterations of the mucosa commonly found in fibrocystic disease. Extensive ulceration, foreign body reaction and calcium deposition in the bowel wall were observed in five cases. Sections through the site of obstruction in one patient showed narrowing of the diameter of the bowel with preservation of muscular layers, but replacement of the central portion by a vascular, fibrous diaphragm in which giant cells, hemosiderin and calcium were prominent. This suggested that in certain instances obstruction of the intestine may be caused by fibrosis secondary to injury of the mucosa by abnormal meconium.

Awareness of the common association of intestinal obstruction and fibrocystic disease of the pancreas and recognition of the histologic change in the bowel in fibrocystic disease may lead to early diagnosis of this disorder in some infants with intestinal obstruction.

THE ASSOCIATION of intestinal obstruction with fibrocystic disease of the pancreas has been the subject of several reports during the past two decades.* Landsteiner's[6] original report of meconium ileus in 1905 has been followed by reviews of this subject with increasing frequency. Although impaction of meconium is the usual cause of intestinal obstruction in fibrocystic disease of the pancreas, other factors may be responsible, such as volvulus, peritoneal bands, atresia and stenosis of the intestine.[9] The incidence of atresia of the intestine observed at operation and necropsy is unexpectedly high with fibrocystic disease.

Our interest in this problem was aroused when two neonates were successfully treated surgically for atresia of the intestine and subsequently had clinical fibrocystic disease of the pancreas, later confirmed at necropsy. In an effort to determine the incidence of fibrocystic disease in association with intestinal obstruction, we reviewed the records of cases of stenosis and atresia of the bowel at the Children's Hospital of Los Angeles, omitting those with volvulus, peritoneal bands, meconium ileus or meconium peritonitis. Complete reports of postmortem examination were available in 41 of 103 cases. Seven of these revealed histopathologic changes in the pancreas consistent with fibrocystic disease. Two additional patients were included whose pancreas was not available for study but whose histories and clinical course leave the diagnosis of fibrocystic disease of the pancreas in little doubt.

The purpose of this paper is to present these cases, adding support to the premise that the associated atresia or stenosis may be a part of fibrocystic disease itself, and to suggest that histologic study of surgical specimens may lead to early recognition of fibrocystic disease of the pancreas in these patients.

REPORTS OF CASES

CASE 1. A one-day old Caucasian girl was admitted to the Children's Hospital with vomiting, abdominal distention and absence of stools since birth. She was the third child of apparently healthy parents. One sibling, age 15 months, was alive and well. Another died at this hospital of fibrocystic disease at ten months of age. Pregnancy and delivery were uncomplicated and no abnormalities were noted at birth.

Respirations were rapid and shallow and the abdomen was greatly distended and tympanitic. Peristaltic sounds were audible. The clinical diagnosis of meconium ileus was strengthened by the radiographic observation of dilated loops of small intestine and little air in the bowel distal to the distended segments. At laparotomy dilated loops of upper jejunum were found which adhered to adjacent loops of bowel and parietal peritoneum. One loop of jejunum had perforated and appeared extensively necrotic just proximal to an area of narrowing which was thought to represent stenosis or atresia. Distally the intestine was unusually small and wormlike. A double-barrel jejunostomy was constructed and exteriorized. Postoperatively the infant did poorly and died the following day. Autopsy was not done.

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From the Children's Hospital of Los Angeles, and the Departments of Pediatrics and Pathology, University of Southern California School of Medicine, Los Angeles 33.

*References 3, 4, 5, 7, 8, 9, 10.

CASE 2. A two-day-old Caucasian girl was admitted to the Children's Hospital because of vomiting of bile, abdominal distention and the absence of bowel movement since birth. She was the third child of healthy young parents. Two siblings were living and well. The pregnancy was complicated in the last two weeks by periorbital and ankle edema but delivery was uneventful.

On physical examination the distended abdomen felt lumpy to palpation, and peristaltic sounds were faint. Because intestinal obstruction was suspected the abdomen was opened. A large loop of upper ileum contained extremely rubbery greenish material. Distally, the intestinal diameter suddenly decreased. The remaining bowel appeared underdeveloped. The obstructed loop was resected and end-to-end anastomosis was carried out.

Persisting obstruction required surgical intervention on the fifth postoperative day. As the site of the previous anastomosis was the point of obstruction, the area was by-passed by a side-to-side anastomosis. The infant improved slowly thereafter and was discharged from the hospital at the age of 23 days. During the stay in hospital the stools and duodenal juice revealed no tryptic activity. About one month following discharge from the hospital a cough and mild expiratory wheeze were noted and they became progressively more severe. Despite dietary measures and the use of wide spectrum antibiotics, the condition of the patient deteriorated gradually and she died at the age of two months. Necropsy was performed.

CASE 3. A 36-hour old Caucasian boy was admitted to the Children's Hospital because of vomiting, increasing abdominal distention and the absence of bowel movements for 24 hours. No family history was available.

The infant was in moderate distress. Respirations were rapid and irregular. The abdomen was grossly distended and tympanitic and veins over the upper abdomen were prominent. X-ray films confirmed a clinical impression of intestinal obstruction and at laparotomy the proximal one-fifth of the small intestine was greatly expanded and it ended in a blind pouch. The distal four-fifths of the intestine was underdeveloped and filled with thick meconium. The distal jejunum was excised to a point at which the development appeared normal, and a side-to-side anastomosis was constructed.

The postoperative course was marked by vomiting and continued distention, necessitating surgical intervention on the seventh postoperative day. The obstruction was caused by an angulation at the site of earlier anastomosis. The anastomosis was entirely resected and a new one was made side-to-side. The patient improved gradually until the 27th day, when a moderate cough developed and became progressively worse despite antibiotic therapy. Fibrocystic disease of the pancreas was suspected, but attempts at duodenal drainage were unsuccessful. Three consecutive stool specimens showed no tryptic activity by the x-ray film technique. The condition of the patient deteriorated and he died at 44 days of age. Necropsy was performed.

CASE 4. The patient, a three and a half day old Caucasian girl, had been born with a distended abdomen and had begun vomiting bile soon after birth. She had passed no meconium. Vomiting and distention became progressively worse and the infant was admitted to the Children's Hospital. Pregnancy and delivery had been normal. The parents were young and healthy. Two half siblings were living and well, and one full sister of the patient had clinical fibrocystic disease of the pancreas.

The patient was severely dehydrated, cyanotic and critically ill. The abdomen was grossly distended. Veins over the surface of the abdomen were prominent and loops of bowel were palpable. Peristaltic sounds were not heard. The clinical diagnosis was meconium ileus and x-ray films were consistent with high intestinal obstruction. At operation the wall of a dilated loop of necrotic intestine was seen when the abdomen was opened. A perforation was demonstrated within this section of small bowel, which had a blind pouch just distal to it. Beyond this, the intestine was underdeveloped. The necrotic section of bowel was resected and continuity restored by side-to-side anastomosis. Postoperatively, the patient improved gradually and she was discharged from the hospital at the age of 45 days. Before discharge, stools tested for trypsin by the x-ray film technique revealed no evidence of this enzyme. Subsequently—the patient then being observed elsewhere—clinical symptoms of fibrocystic disease of the pancreas developed and she died. Necropsy was not done.

CASE 5. A one-day-old Caucasian girl was delivered three weeks prematurely. Birth was difficult and forceps had to be used because of a greatly distended abdomen. Following delivery, 365 cc. of a material the color and consistency of pea soup was aspirated from the abdomen. Vomiting of bile-stained material occurred soon thereafter. The family history was noncontributory (but four years later a sibling was admitted to this hospital with severe pulmonary manifestations of fibrocystic disease, confirmed at necropsy).

The patient appeared severely ill and the abdomen was decidedly distended and tympanitic. The area immediately above the umbilicus was discolored. X-ray films of the abdomen showed several loops of distended small bowel. At operation a cystic mass filling the right gutter and extending across the midline was observed. It appeared to be attached to the

undersurface of the umbilicus. The mass contained caseous material the consistency of pea soup. The terminal ileum and entire colon were described as atretic. No description of the caliber of intestine entering this mass was given. The infant died the day following operation. Necropsy was performed.

CASE 6. An 18-hour-old Caucasian girl was put in hospital because of vomiting, distention and absence of meconium stool. Pregnancy and delivery had been uncomplicated, and the family history was noncontributory. The patient did not appear acutely ill but the abdomen was symmetrically distended, and visible intestinal patterns were prominent. X-ray films of the abdomen showed dilated loops of bowel with fluid levels. At operation the proximal two feet of jejunum were extremely dilated and hyperemic. Distally the lumen ceased and there was an atretic area for a distance of about 5 cm. beyond which the entire small and large intestine was collapsed and contained numerous areas of apparent stenosis. The blind ends of the atretic segments were exteriorized. Considerable vomiting and abdominal distention persisted after operation and the patient died seven days later. Necropsy was performed.

CASE 7. An 18-hour-old Caucasian girl was born with a distended abdomen after an uneventful pregnancy and delivery. There was no vomiting but the abdomen became progressively more distended and there was no passage of meconium. The patient was admitted to Children's Hospital. Family history was noncontributory. X-ray films of the abdomen were consistent with obstruction of the small bowel. At operation a large sac of fecal matter was observed and there was a well demarcated but widespread reactive membrane plastered against the viscera. A dilated loop of small bowel entered this mass and a small loop left it. The ileum was packed with firm inspissated material. When the small bowel was freed around the fecal mass, a definite volvulus was noted. The two ends of bowel were exteriorized. The infant did poorly after operation and died 17 days later. Necropsy was performed.

CASE 8. A 34-hour-old Caucasian girl was transferred to Children's Hospital because of progressive abdominal distention and bile-stained emesis. She was the third child of healthy parents. Two other siblings were living, one well and the other with a congenital malformation of the heart. The abdomen was grossly distended and tympanitic. Peristalsis was hyperactive. X-ray films of the abdomen were consistent with obstruction of the small bowel. At laparotomy the distal eight inches of the ileum was observed to contain thick tenacious meconium. Proximally the ileum was greatly dilated for about 18 inches and at the end of the enlarged section there was an area of atresia or pronounced stenosis. Proximal to this area there was localized perforation and peritonitis. The colon was very small throughout its length. The area of atresia or stenosis was resected and end-to-end anastomosis was carried out.

Postoperatively, pronounced abdominal distention continued. X-ray films showed pneumoperitoneum and a second abdominal exploration was necessary to reconstruct the leaking anastomosis. The child did poorly thereafter and died one day after the second operation. Necropsy was performed.

CASE 9. A Caucasian boy was admitted to hospital at the age of six hours because of abdominal distention. Pregnancy had been complicated by hydramnios.

The patient appeared to be critically ill. Veins about the umbilicus were dilated, the abdomen was distended and there were no sounds of peristalsis. X-ray films showed the stomach, duodenum and upper jejunum to be distended. The clinical diagnosis was intestinal obstruction with perforation and peritonitis.

At operation the jejunum was atretic and its proximal and distal portions were completely separated. The upper segment ended in a massive perforation and the abdominal cavity was filled with amniotic fluid and meconium. The areas of atresia and perforation were resected and a side-to-side anastomosis constructed. The child did poorly and died three days after operation. Necropsy was performed.

These patients were predominantly Caucasian and female (Table 1) as are most patients with fibrocystic disease.[1] Shortly after birth, all had such symptoms of intestinal obstruction as vomiting, abdominal distention and failure to pass meconium. Complete or partial occlusion of the jejunum or ileum was observed at operation, with complete separation of proximal and distal segments of the intestine in three cases. Intestinal perforation and peritonitis had occurred in six. Operative procedures included jejunostomy, end-to-end anastomosis and side-to-side anastomosis. Three patients had to have a second operation. Two of the nine were cured of intestinal obstruction and returned home, but both died later of fibrocystic disease. The remaining seven died in the hospital a few hours to six weeks after operation.

PATHOLOGY

Fibrocystic disease of the pancreas was proven by necropsy in seven cases. The family history and clinical course of the two patients not examined postmortem are considered sufficient to establish the diagnosis beyond reasonable doubt. In one patient stenosis of the extrahepatic biliary tree was observed at autopsy. No other congenital malformations were noted.

TABLE 1.—*Summary of Clinical Data in Nine Cases of Intestinal Obstruction in Newborn Associated with Fibrocystic Diseases of the Pancreas*

Case No.	Sex	Age at Onset of Symptoms	Site of Obstruction	Type of Obstruction	Perforation	Operative Procedure	Age at Death	Diagnosis of Fibrocystic Disease	Comment
1.	F	Birth	Jejunum	Atresia	+	Jejunostomy	2 days	Clinical	
2.	F	Birth	Ileum	Stenosis	—	(1) End-to-end anastomosis (2) Side-to-side anastomosis	2 mos.	Necropsy	Required second operation
3.	M	12 hr.	Jejunum	Complete atresia with separation of segments	—	(1) Side-to-side anastomosis (2) Side-to-side anastomosis	44 days	Necropsy	Required second operation
4.	F	Birth	Ileum or jejunum	Complete atresia with separation of segments	+	Side-to-side anastomosis	10 mos.	Clinical	
5.	F	In utero	Ileum	Atresia	+	Exploratory only	2 days	Necropsy	
6.	F	Birth	Jejunum	Atresia	—	Jejunostomy	8 days	Necropsy	
7.	F	In utero	Jejunum	Stenosis and volvulus	+	Jejunostomy	18 days	Necropsy	
8.	F	Birth	Ileum	Stenosis or atresia	+	(1) End-to-end anastomosis (2) Reconstruction of anastomosis	9 days	Necropsy	Required second operation
9.	M	Birth	Jejunum	Complete atresia with separation of segments	+	Side-to-side anastomosis	3 days	Necropsy	Pregnancy complicated by hydramnios

Histologic specimens of intestine removed at operation or at necropsy were available in all cases, and two kinds of pathologic changes were noted. The mucosal changes commonly observed in fibrocystic disease[2] were present in all patients. These are illustrated in Figures 1 and 2 and include (1) increase in the number and activity of goblet cells in the small intestinal glands, (2) dilatation of glands with occasional formation of cysts, and (3) masses of pink inspissated material within the glands. Occasionally these alterations, especially the third, may be observed in patients without fibrocystic disease of the pancreas, but rarely to the same degree. They appear to be related to the general disorder of glandular function associated with fibrocystic disease of the pancreas. When such changes are observed in surgical or postmortem specimens, suspicion of this disorder should be aroused.

Extensive ulceration of the mucosa and deposition of calcium were observed in five specimens (Cases 1, 3, 4, 7 and 9; Figures 3 and 4). In some specimens the surface of the bowel was replaced by coagulative necrosis, with masses of calcium scattered through pink, granular debris. In others, a dense layer of calcium replaced mucosa and extended deep into the underlying tissues. Cellular reaction was chronic in nature, largely phagocytic and including giant cells. One of the most striking alterations was the extensive deposition of calcium in the

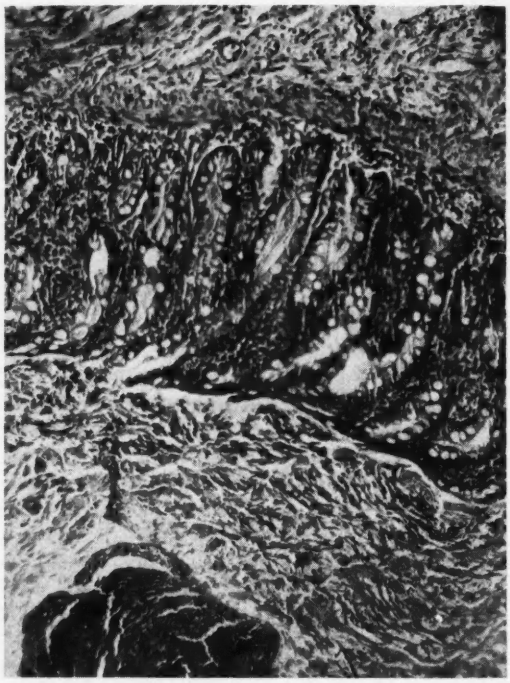

Figure 1.—Mucosal changes in fibrocystic disease of the pancreas: Increase of goblet cells, dilatation of glands, masses of inspissated material in glands (× ±300).

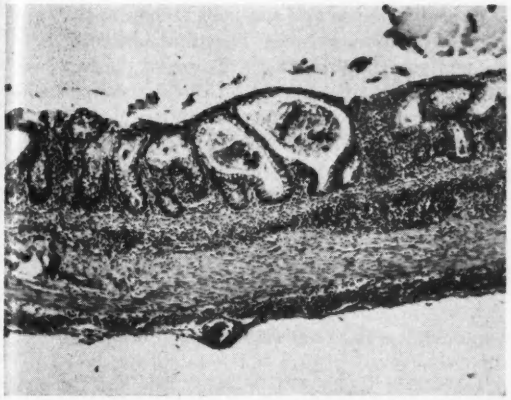

Figure 2.—Mucosal changes in fibrocystic disease of the pancreas—cyst formation (× ±100).

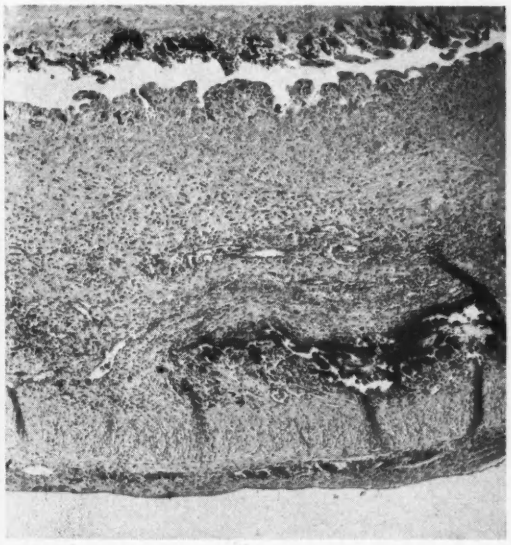

Figure 3.—Ulceration and calcification of bowel wall in case of atresia in patient with fibrocystic disease (× ±180).

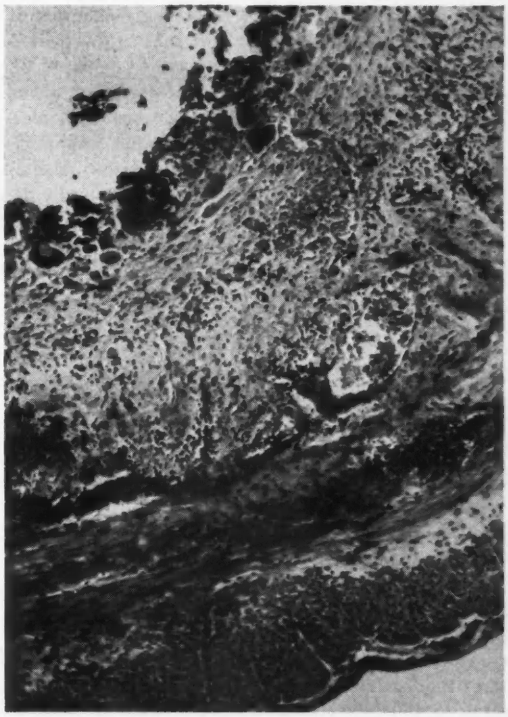

Figure 4.—Calcification and foreign body reaction in case of atresia with fibrocystic disease (× ±300).

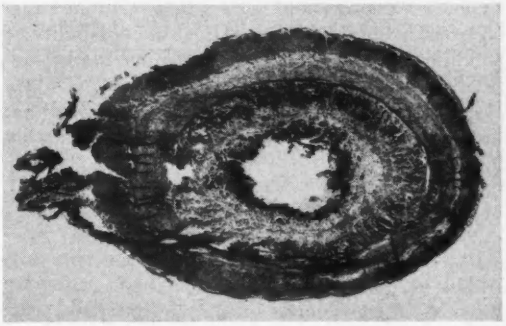

Figure 5.—Case 1, showing narrowing of diameter of bowel, central diaphragm and calcium deposition (× ±15).

muscle layers. In some specimens an entire layer of muscle was replaced by calcium for the width of several low-power microscopic fields. Small foci of foreign body reaction and calcification were also present in the subserosa. Occasionally keratinized epithelial cells were visible in such lesions.

The changes noted in Case 1 deserve particular attention (Figure 5). Specimens taken adjacent to and remote from the site of obstruction showed the pathologic features described above. Sections from the site of obstruction itself, however, showed narrowing of the diameter of the bowel with muscle layers intact and the central portion consisting of a fibrous diaphragm of young, vascular connective tissue containing numerous giant cells, lymphocytes and phagocytes filled with hemosiderin. No epithelium was evident, and there was a large mass of calcium where a lumen might have been expected. The histologic nature of the lesion suggested reparative fibrosis.

DISCUSSION

Zuelzer[10] and LeLong[7] described cases similar to Case 1 in the present report, which gives rise to a postulation that the obstruction was secondary to fibrocystic disease rather than a primary arrest of

development. In meconium ileus, the meconium is extremely viscid and tightly adherent to the intestinal wall. It is probable that the same is true of all cases of fibrocystic disease in lesser degree. It seems possible, therefore, that in certain cases peristalsis may act upon such abnormal meconium with sufficient vigor to cause ulceration of the intestinal mucosa, permitting penetration of meconium into the submucosal layers. The result might be a foreign body reaction, scarring and, eventually, complete occlusion. Certainly Case 1 in this report and the cases cited suggest this as an attractive explanation of obstruction in patients with fibrocystic disease. However, partial or complete occlusion of the intestine is equally possible on a developmental basis, abnormal meconium in the segment proximal to the obstruction producing the alterations observed in the bowel wall of the patients in the present series. The correct interpretation will depend on further study.

The high incidence of fibrocystic disease in cases of atresia or stenosis of the ileum and jejunum in the newborn is much more important. Levy,[8] in 1951, found nine reported instances of this association in a review of intestinal obstruction in fibrocystic disease. The cases in the present report constitute approximately 10 per cent of all cases of atresia or stenosis of the small intestine in this hospital. Pediatricians and surgeons should be alert to the possibility of fibrocystic disease whenever neonatal intestinal obstruction is suspected. As surgical techniques improve and more infants with intestinal obstruction survive the operation, the possibility of an ultimately unfavorable prognosis due to fibrocystic disease should be recognized. Further, if fibrocystic disease is recognized early, it is possible that the course of that disorder might be favorably influenced.

As pediatricians and surgeons recognize the common association between intestinal obstruction of the newborn and fibrocystic disease of the pancreas, and as pathologists recognize the suggestive histologic alterations in specimens of bowel wall, suspicion of the disease should be aroused early. Confirmatory tests such as analysis of sweat and duodenal secretions should then lead to confirmation or exclusion of the diagnosis, and early institution of therapeutic measures.

4614 Sunset Boulevard, Los Angeles 27 (Cleland).

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Neurologically Handicapped Children

The Role of the Pediatrician in Rehabilitation

GORDON F. WILLIAMS, M.D., Palo Alto

• **In the application of the broad services now available to assist a child having a major neurologic impairment, the pediatrician occupies an important role owing to his ability to consider the problem of the handicapped child in the context of his specialized knowledge of the developmental process. He thus has a large responsibility for interpretation of the problem to the child, to the parents and to his professional colleagues and for guidance of the rehabilitation regimen within the limits of the child's developmental readiness for new experiences.**

The pediatrician has the opportunity to contribute significant clinical observations which may provide stimuli for future basic research and to exercise his skill as a practitioner of preventive medicine.

Goals for the future achievement of the child having a major neurologic impairment must be set realistically and with great caution.

IN THE PAST DECADE much has been learned about the techniques of rehabilitation. The philosophy of rehabilitation, embodying as it does attention not only to the physical but also to the emotional, the social and the educational aspects of the crippling disorders of childhood, has been epitomized in several excellent reviews which have appeared in the pediatric literature within the past decade.[5,10,12,24] Much emphasis has been given to the "multidisciplined approach"[27] on the basis that the assault on the multiple problems of the severely disabled child —for example, the child having a neurologic handicap—requires a battery of skills too diverse to be encompassed by any individual physician.

In recent years numerous elaborate rehabilitation centers have come into being, staffed by large numbers of medical specialists with coworkers from such other professions as psychology, social work, speech pathology and audiology, physical therapy and occupational therapy. These are generally located in the more densely populated urban areas. In addition, educators have given much attention to the problems of the handicapped child, particularly to those of the child having a neurologic impairment, with the result that in many areas such children are segregated in special schools for the disabled throughout their scholastic experience.

In the consideration of problems of the child having a neurologic impairment, much emphasis has been given to methods of evaluation and management. Techniques for early case-finding,[26] for classification of the neurologic deficit,[2] for detection of associated damage to the visual and acoustic apparatus,[7,22] for assessment of disability in the areas of language and communication[1,13] and for the psychologic appraisal of the brain-damaged child[14,18] are given extended discussion. In the fields of physical therapy[6] and of occupational therapy,[17] those concerned with the practical aspects of assisting the child toward the development of specific neuromuscular skills have evolved elaborate regimens which can be employed only by those having a highly specialized background of training. Educators have published extensively, often in conjunction with psychologists, on the particular learning disabilities encountered in children having impairments of the central nervous system and on the special techniques of education that have proved most rewarding in this field.[9,23]

Methods for parent counseling, and in particular group therapy techniques,[16,19] have been tested with parents of children having a variety of handicaps and have proved fruitful in assisting parents toward the development of insight into the dynamics of their relationships with their handicapped and frequently emotionally disturbed children. In addition, the sociologists and the cultural anthropologists[24] have asked that due consideration be given to community and cultural factors as they relate to the individual undergoing what now appears to be the almost overwhelming experience of becoming rehabilitated.

In view of the special knowledge required, it would be small wonder if the pediatrician, looking upon himself now as a generalist, should feel abashed and even at times bewildered. When considering the complexities that have been devised for the study and care of patients handicapped by neurologic deficits, one can visualize the pediatrician asking himself in the dead of night, "Am I a sociologist, a social worker, a psychologist? Am I a neurologist, a physiatrist? Where do I fit in? What is

From the Stanford Convalescent Home, and Department of Pediatrics, Stanford University School of Medicine, Palo Alto.

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my role?" He may well reflect that the "multidisciplined approach," although it has proved useful in bringing to light many specialized aspects of the complex problem of central nervous system impairment, has also built within it the potential for creating in his patients and their families an even larger degree of confusion than he had felt momentarily when he paused for self-scrutiny. The pediatrician must remind himself that only he, of all the professional people with whom his patient may have contact, can view the child's total situation with the perspective and wisdom that a specialized knowledge of the process of development permits. With his knowledge of the ramifications of the developmental process the pediatrician is in a position to evaluate the dynamic significance of one aspect or another of defective neurologic function. He is the only one in a position to interpret to the parent the significance of the neurologic impairment as it relates to aptitude of intellectual function, perceptual ability and learning capability and how these in turn relate to emotional maturity and to the image that the child has formed of himself. It is his large responsibility to interpret these matters to the parent in the light of his own knowledge of the complexities of the developmental process.

Although the pediatrician here finds himself in the role of a teacher to the parent, he has another more primary role, even more important. With his knowledge of the dynamic process of growth and development of the central nervous system, he is in the unique position of capability for assigning values to the various manifestations of neurologic dysfunction which may be manifested by reflex activity, by lack of cortical inhibition, by ataxia, dystonia or the like. His sophistication in matters pertaining to the developmental process permits him to relate laboratory and electroencephalographic findings to the physical and psychologic attributes of his patient as he views him in a given moment of time. This knowledge of the basic processes underlying the total development of the child and, more specifically, what is known of the biochemical development of the central nervous system, permits the pediatrician to recognize his patient's readiness or lack of readiness for new experiences and specifically for any new mode of therapy, training or scholastic instruction that may be planned. Thus, recognizing the importance of tailoring treatment regimens and scholastic programs in such a fashion that they will be the most appropriate for his patient's developmental level and for his emotional readiness for new experiences, the pediatrician will be in constant touch with the physical therapist, the speech therapist and the teacher, truly coordinating their activities in a fashion that will permit his patient to make the maximum gains from the specialized help that is offered him. Likewise, his knowledge of the intimate parent-child interaction will permit him an understanding of the forces pertaining in the home which will permit optimal developmental progress on the one hand, or, in a situation in which a disturbed relationship exists, an interference with the developmental process and consequent complications in the therapeutic or learning situation.

CAUSES OF NEUROLOGIC IMPAIRMENT

The major disabilities of the central nervous system seen in infancy and childhood may be divided into those having their origin in a genetic abnormality of the germ plasm or otherwise originating

TABLE 1.—*Classification of Causes of Neurologic Impairment in the Developing Organism*

Period of Onset	Underlying Disturbance	Examples
Prenatal	1. Genetic disorder	a. Gargoylism b. Lipoid storage diseases c. Galactosemia d. Phenylketonuria
	2. Congenital malformation	a. Myelodysplasia b. Craniostenosis
	3. Infection	a. Toxoplasmosis b. Maternal rubella
Perinatal	1. Infection	a. Sepsis
	2. Trauma, hypoxia or vascular injury	a. Spastic quadriplegia or hemiplegia
	3. Endogenous neurotoxic agent	a. Hyperbilirubinemia
Postnatal	1. Metabolic	a. Porphyria
	2. Nutritional	a. Convulsive state related to pyridoxin deficiency
	3. Infection	a. Viral encephalitis b. Suppurative meningitis
	4. Trauma, hypoxia or vascular injury	a. Hemiplegia, quadriplegia
	5. Neoplasm	a. Glioma, ependymoma
	6. Exogenous toxic substances	a. Lead encephalopathy b. Drug toxicities

in prenatal life, those which originate during the perinatal period and those having their beginnings at some point in the postnatal period. These may, in turn, be divided into those expressing themselves in a metabolic dysfunction (of which a majority have an essentially genetic basis); those manifesting themselves by congenital malformation (of which some have a clearly genetic basis and some appear to be related to environmental insult during intrauterine life); those related clearly to infection; those related to trauma or vascular damage; those related to specific nutritional lack; those related to endocrine abnormality; those due to neoplasms of the brain; those due to endogenous neurotoxic substances; and those in which central nervous system dysfunction is due to the action of an exogenous poison. There is considerable overlap in these categories. Table 1 provides a far from complete listing of examples of these several categories of disorders of the central nervous system.

The pediatrician has the opportunity to play the most significant role in the detection of brain injury. Through his close relationship with child and family he is apt to be the first to become aware of a deviation from the smooth course of normal development, and so to arrive at a diagnosis of impairment in neurologic function. Beyond this, the pediatrician has an even more exciting opportunity. With him lies the potential, through his critical clinical observations, for uncovering previously unrecognized basic processes which may lead to central nervous system dysfunction. An example will suffice: In 1954 Hunt and his collaborators[11] observed a young infant having intractable convulsive seizures. Through an elegant plan of clinical study they were able to define that this baby's convulsive difficulty was based on what they characterized as "pyridoxine dependence." The administration of pyridoxine controlled the seizures. Later others,[3] observing convulsive phenomena in infants, fed a proprietary milk mixture which lacked pyridoxine, confirmed Hunt's earlier observation and were able to define the requirement of the infant for this essential nutrient substance. In the meantime the biochemists,[21,25] studying the metabolic effects on the brain of pyridoxine deprivation, were able to define that the occurrence of epileptiform seizures in the experimental animal so deprived is correlated with a specific decrease of glutamic decarboxylase activity (for which pyridoxine serves as a coenzyme) with consequent failure in the formation of γ-aminobutyric acid, an amino acid found only in the tissue of the central nervous system. Further basic research has disclosed that in all cases of epileptiform seizures studied, both in the experimental animal and in brain excised from human beings having focal epilepsy, there is evidence for involvement of glutamic acid itself or of γ-aminobutyric acid.

A further opportunity of the pediatrician has to do with his role in early case-finding. Here, through the accurate identification of a metabolic disorder in the young infant, at a stage prior to the development of major significant brain damage, he may be able to control the metabolic dysfunction through dietary or other means and so permit the child unimpaired brain development which would otherwise have been denied. The employment of a lactose-free diet in galactosemia[15] and of a dietary low in phenylalanine in phenylketonuric patients[4] are examples familiar to everyone. These examples point up the growing importance of improvement of our understanding of genetic disturbances.[20] A tool which would permit the identification of the heterozygote in either of the situations cited here, or in many of the other traits transmitted by an autosomal recessive gene, would be invaluable in permitting the early identification of the homozygous individual and the application of appropriate measures for management where these are feasible.

GOALS IN THE REHABILITATION

In planning a program for a child having a major neurologic deficit, multiple areas must be considered, as has been pointed out earlier. These include the management of the physical aspects of the disability with appropriate consideration being given to the child's intellectual capacity, to his level of emotional maturity and perhaps particularly to the image he has of himself, as well as to the fashion in which he relates to his peers and to adults. His educability, and particularly the fashion in which he perceives spatial relationships, as well as his manner of performance in certain disciplined activities such as reading, writing and the use of numbers, requires careful consideration. Lastly, detailed knowledge of his family and of his home situation are essential. The impact upon the parents and indeed upon the entire family, as it can be defined in terms of economic stress, of guilt and of anxiety, of the ambivalence that the parents may feel toward the handicapped child in terms of overprotection on the one hand and rejection on the other, is a matter which cannot be underestimated. Here the collaborative services of a skilled social worker are invaluable to the busy physician. Not only can the social worker be useful in interpreting to the family the interplay of feelings which predictably occur in this sort of situation, but her knowledge of community resources available to the physician, which will assist him in meeting the needs of the family, can be most helpful.

TABLE 2.—*Intellectual Competence of Brain-Damaged Patients*[8]

Intellectual Competence Category	Pyramidal Involvement Only		Extra-pyramidal Involvement Only	
	No.	Per Cent	No.	Per Cent
Superior	12	4	11	12
Average	53	19	31	33
Borderline	71	26	20	22
Defective	62	23	19	20
Low-grade defective	75	28	12	13
Total	273	100	93	100

Perhaps the most serious pitfall that is met in the process of rehabilitation is that of setting unrealistic goals. This is well illustrated in Table 2, which is an adaptation of Bronson Crothers'[8] data on a large group of brain-damaged children who were observed carefully, with repeated determinations of intellectual functioning, psychologic aptitude and performance over an extended period.

The data speak for themselves. They are, to say the least, depressing. It seems obvious that, in this group of children where almost half are patently mentally defective, the goals to be anticipated in terms of future achievement must be set with great caution. The parents must be carefully and gradually prepared to view the future with realism. The rate of salvage, placed in terms of the likelihood of future independence and important contribution to society, will be low. A similarly cautious prognosis must be given with regard to the child who has developed manifestations of severe personality disturbance with relation to his disability.

520 Willow Road, Palo Alto.

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Malignant Degeneration in Burn Scars

SALVADOR CASTAÑARES, M.S., M.D., Los Angeles

• **The malignant potential of burn scars has been recognized since Marjolin's classical description of cancer arising in several types of post-traumatic scars.**

With improved burn therapy since the last war, there has been a higher survival rate of severe burns with proportionate increase in cancer associated with burn scars. This will create increasing problems of permanent disability and compensation.

The younger the patient at the time of the burn, the longer the time required for the cancer to develop. Acute cancer development in burn scars has been reported after a four-week interval. Cancer may develop from six weeks to fifty years or more.

The etiology of cancer in burn scars is not known. The most important clinical finding is the fact that most of the burn cancers occur in areas which were not grafted.

The most common type of cancer encountered in burn scars is squamous cell carcinoma, which forms in Marjolin ulcers. Basal cell carcinoma may develop in the most superficial of burn scars.

Treatment should be directed primarily to prompt and adequate skin grafting in all deep burns in order to prevent malignant degeneration of the burn scars. Once it has developed the treatment is the same as for other malignancies which are not associated with burns. Wide surgical excision with block dissection of the regional lymph nodes when they are involved is the treatment of choice. The prognosis of burn scar cancer is poor, once the process has extended because of early and distant metastasis.

THE PLASTIC SURGERY PROBLEMS that are related to industrial medicine are many, particularly with regard to injuries resulting in functional and cosmetic disabilities. One that stands out in increasing importance is the problem of malignant degeneration in burn scars.

The malignant potential of burn scars has been recognized before. In 1828 Jean-Nicholas Marjolin[11] wrote his classical description of cancer arising in post-traumatic scars of several types, but since, the term *Marjolin ulcer* has come to be used particularly to describe malignant changes occurring in burn scars.

Owing to improvements in burn therapy that derived from the experience of World War II the survival rate of persons with severe burns has risen. A concomitant has been an increase in the problem of cancer associated with burn scars, and a proportionate increase also in the problems of permanent disability, compensation and litigation, particularly with regard to industrial accident cases. The liability of insurance carriers in cases of malignant change as a complication of a burn either soon or many years after the injury will have to be determined through legal decision. It is felt that our present legal ruling rests on an unsure foundation, due to lack of etiologic knowledge of cancer. This may change, however, as we gain more insight into the general and specific causes of cancer, and into the relationship of all types of trauma to malignant change.[2]

Malignant changes in burn scars may occur in any race and at any age, although they are seen predominantly in adults, particularly in males. Studies show that approximately 78 per cent of all Marjolin ulcers occur in males. Malignant lesions of this order occur predominantly in the extremities and on the head: 38 per cent occur in the lower extremities, 22 per cent in the upper extremities, 30 per cent on the head and 10 per cent on the trunk. Various investigators have reported between 9 per cent[1] and 24 per cent[3] of all types of cancers in the extremities originate from burn scars.

The younger the patient is at the time of the burn, the longer it takes for cancer to develop.[10] It may take 40 or 50 years after burns in childhood but from only a few months up to nine years for patients burned after age 50.

Horton and coworkers[7] reported various cases in which malignant change developed from six weeks to 36 years after the original burn.

McLeod[12] and Stauffer[14] reported malignant degeneration after four weeks in some cases. This is the shortest period reported. Roffo[13] reported a latent period of 60 years, which is the longest noted in the literature.

The cause of malignant change in burn scars is not known. There are several theories, as is the case regarding cancer in general. Virchow's theory of chronic irritation seems to be the most plausible, since most malignant tumors develop at the site of a large, chronic, draining irritated wound, or at a place of cicatricial contracture,[5] where there is con-

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From the University of Southern California School of Medicine, Los Angeles 33.

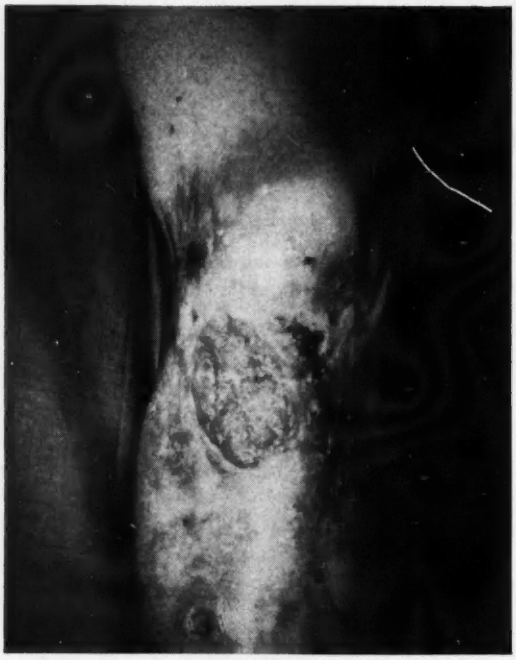

Figure 1.—Nineteen-year-old burn scar with frequent and persistent breakdowns, resulting in chronic, draining and irritated wound. Marjolin ulcer formation, and finally in squamous cell carcinoma degeneration. On examination it was found the malignant process had invaded muscles, tendons and bone. In spite of amputation the patient died of distant metastatic carcinoma.

tinuous stress and strain with frequent and persistent breakdowns.

Constant exposure of a burn scar to oils or certain chemicals has been considered a factor in industrial jobs. It is well known that certain oils and chemicals contain carcinogenic substances.[4]

The most important clinical finding, however, is that most of the cancers in burn scars occur in areas that have not been grafted. The greatest incidence is associated with deep burns that healed slowly, remaining ulcerated and irritated over long periods.

The most common type of cancer encountered in burn scars is squamous cell carcinoma, which forms in Marjolin ulcers, originating in thick scar tissue. These lesions may invade muscle, tendon or bone, although they extend slowly. The scar tissue may undergo alternating changes of healing and ulceration, may become thickened and resemble a keloid, or may remain superficial and loose.[9] Invariably in malignant lesions in burn scars, inflammation and infection develop, which may stimulate growth and metastasis.

In the most superficial burn scars, in which the hair follicles and sweat glands have not been destroyed, basal cell carcinomas may develop.

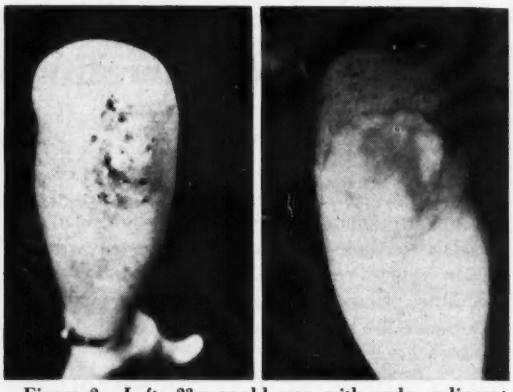

Figure 2.—*Left:* 23-year-old scar, with early malignant degeneration. *Right:* After wide surgical excision followed by thick split-thickness skin graft.

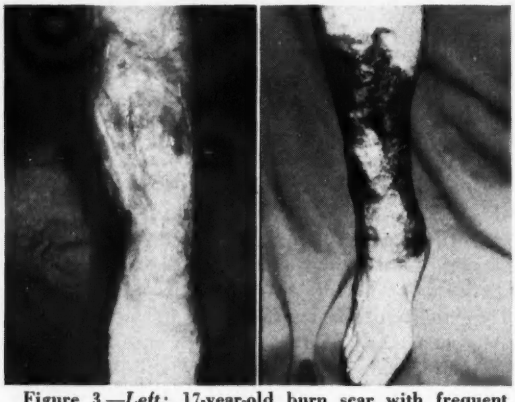

Figure 3.—*Left:* 17-year-old burn scar with frequent breakdowns, ulceration and infection. Biopsy revealed squamous cell carcinoma. *Right:* After extensive and deep excision of ulcerated areas, including adjacent intact burn scars followed by split-thickness skin graft. Note unpredictable hyperpigmentation changes of the healed skin graft.

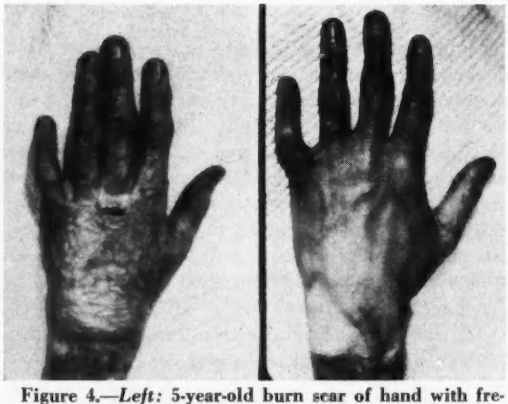

Figure 4.—*Left:* 5-year-old burn scar of hand with frequent breakdown, final ulceration and early malignant degeneration to basal cell carcinoma. *Right:* After resection of entire dry and thick scar from dorsum of hand and fingers and resurfacing with large split-thickness skin graft.

Fleming[6] reported the development of sarcoma in old burn scars, stating that there is malignant potential contained within the deeper tissues adjacent to a burn.

It is very difficult to prove or disprove that a premalignant tendency of the skin existed before the burn in the rare cases of acute burn scar cancer occurring within a year after a burn.[8]

TREATMENT

There is no better dressing for a third-degree burn than skin. Consequently, in order to prevent burn scar cancers, prompt and adequate skin grafting should be done in all cases of deep burns. After the initial healing, all secondary contractures with evidence of breakdowns and continuous stress and irritation should be treated either by skin grafting, flap rotation, Z-plasty procedures or a combination of the above.

The treatment of a malignant lesion in a burn scar is the same as for the same kind of lesions not associated with burns. Wide surgical excision is the treatment of choice, with block dissection of the regional lymph nodes if they are involved.[5]

X-ray and radium are less effective, for some of them are not amenable to radiation and usually there is already considerable fibrosis or scarring present.

Once the process has extended because of early and distant metastasis, the prognosis of burn scar cancer is poor.

1930 Wilshire Boulevard, Los Angeles 57.

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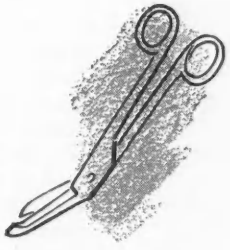

Geriatric In-Patients

The Precipitating Cause of Admittance to the State Hospital

DANIEL A. GRABSKI, *M.D.*, Norwalk

• **The case records of 100 patients over the age of 60 at the time of their admission to a state mental hospital in California were evaluated, using rigid criteria to determine whether the precipitating cause for their state hospitalization was due to a deterioration of their mental state or a change in their socio-environmental milieu. The results of the study indicated that 77 per cent of these patients were in hospital because of a deterioration in their own mental state while 23 per cent were there because of a deterioration in their socio-environmental milieu. The data also were indicative that the proportion of patients put in hospital because of a deterioration in their socio-environmental milieu might conceivably be higher than 23 per cent if subtle changes in family attitude towards the patient could be adequately evaluated.**

NUMEROUS OBSERVERS have noted that more and more geriatric patients have been put into state hospitals during the past decade. The increase in the number is far greater proportionally than the increase in the aged in our population.[1] Several contradictory theories have been propounded to explain this increase.[3,5]

In the present study a small group of patients were evaluated in detail in an attempt to determine the precipitating causes for their admittance to a state hospital in California.

It is recognized that the sample under study may not be representative of national conditions, or for that matter even that of the entire State of California. Commitments from Los Angeles County run statistically lower than those of the less populous counties and an active screening and counseling service offered by the counselors in mental hygiene of the Los Angeles Superior Court is considered largely responsible for this fact.

One hundred consecutive admissions of patients aged 60 or over at the time of admission to the Metropolitan State Hospital, between February and June of 1958, were chosen for evaluation regarding the precipitating cause for admittance.

Information on the case records of these patients was gathered from the following sources:

1. From the patient through the standard anamnesis of the admitting psychiatrist.

2. The legal documents and sworn statements that brought about or enabled the commitment or admittance.

3. The anamnesis as completed by a close family member.

4. Evaluation reports from previous hospitals, including the general hospital while the patient was awaiting the commitment proceedings.

Of this information, the family anamnesis was considered the most valuable. This was most frequently submitted in the close relative's own handwriting and expressed, in much detail—not only the historical data surrounding the patient but also the attitudes of the family members toward the patient. At times evidence of gross family defensiveness was obvious. Perhaps the least valuable information was that obtained by the admitting psychiatrist in routine interview of the patient, for the patients are often confused and disoriented or suspicious and guarded at the time of admittance. In many instances it seemed the hospital was a refuge the patient did not want to jeopardize by discussing.

The information obtained from the above sources was classified into two sections: That in which the mental status of the patient deteriorated, requiring that he be put in hospital; and that in which conditions in the patient's environment changed or deteriorated and resulted in his admittance. Trying for objectivity in a clinical study of subjective data is, of course, fraught with possibility of bias. Information was evaluated in full recognition that arbitrariness was a factor in decision as to category.

The following criteria were used as indicators of deterioration of the patient's mental condition.

1. Self-destructive behavior, including attempts at suicide or serious threats of suicide.

2. Deviant behavior, including the following: (a) Assaultiveness to person or destructiveness to property. (b) Actions based on hallucinations or delusional thinking. (c) Creation of frequent neighborhood disturbances. (d) Bizarre behavior of minor degree requiring 24-hour per day supervision. (e) Withdrawal and apathy with lack of concern over primary bodily needs.

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TABLE 1.—*Reason for Admittance of 100 Geriatric Patients to a State Hospital*

	Patient's Condition	Environment
Male	25	13
Female	52	10
Total	77	23

3. The inability (for other than economic reasons) of a private sanitarium or nursing home to care for the patient.

The following is the list of criteria indicating deterioration in the patient's social environmental conditions precipitating his admittance to hospital.

1. No home.
2. No one willing or able to care for the patient.
3. Obvious serious physical illness requiring intensive and immediate medical care.
4. Commitment incidental to police investigation.

These criteria are grossly evaluated and it is not possible to infer subtle changes in attitude toward the patient from the available data.

The results of this study indicated that 77 per cent of the patients admitted to the state hospital were admitted because of a deterioration in the individual patient's mental condition, while 23 per cent were admitted because of deterioration in the patient's physico-socio-environmental milieu (Table 1).

DISCUSSION

Psychiatrists will see more and more patients who are in their sixties and seventies and older age brackets. The aged population in the United States has increased by more than 11.5 million persons since the turn of the century. In 1900 there were only 3,800,000 persons 65 years of age or over. By 1958 this age group numbered an estimated 15,000,000. While the United States' population has doubled during this period, the number of those aged 65 and over has quadrupled. For a person beyond 65—the "magic dividing line" between middle age and old age—the expectancy of life has not risen by more than two additional years in the last century.[6]

If current trends continue, the future of many of the aged in our population will be to spend their declining years in a state hospital; and many, as has been seen by the data presented, will be there for reasons other than their own mental disturbance.

Kolb[5] expressed belief that it is for sociologic reasons that many old people are sent to mental hospitals rather than for mental health reasons. He said further: "The feeble aged in our complex environment are more difficult to manage than they used to be, and the general attitude toward them has changed, so that people easily convince themselves that institutional life is the proper thing for the feeble old relative. As mental hospitals offer less resistance than other outlets, they drift there in increasing numbers."

Kolb's orientation is admittedly that of a social psychiatrist, but among others with an entirely different point of view who feel that too many aged are being hospitalized in the state hospitals, Horbzczewski, an internist at the Saskatchewan Hospital in Canada, expressed the opinion that vast numbers of aged patients with chronic incapacitating physical illnesses were incorrectly included as psychiatric patients. He said that many of them have few or no psychiatric symptoms, and are in hospitals solely to relieve relatives of tedious nursing needed for incontinence and helplessness, or because they have had to vacate a general hospital bed for patients with acute disease or simply because they have no interested relative. That the physical condition of the geriatric patient is indeed closely related to his admittance to a state hospital can be seen in the informal notation that 20 per cent of the patients in the current study were dead at the time the records were screened, which was only three to six months after their admission.

Bettag,[1]* said that "only one patient in five in these groups [over 65 at admission] will be discharged from our hospitals alive . . . and the other four will end their days under state care." He said that about half of in-patients aged 65 or over in Illinois state hospitals had entered hospital before the age of 65; they were for the most part schizophrenic patients who had been in hospital for long periods. The other half, composed of patients who entered after the age of 65, was composed of patients with cerebral arteriosclerosis and senile brain disease. For them the hospital stay was relatively short and ended with their death. These figures are roughly comparable to the situation in California but we are able to discharge one out of three of our aged patients alive.

Recognizing that nearly one-fourth of the admissions of old persons to state hospitals are the result of conditions other than deterioration of the patient's mental state could be valuable in determining the sector of prophylactic or therapeutic approach with the patient: Should it be directed toward reintegrating the patient through physical, pharmacological or psychological methods—or at manipulating, changing or supporting the social environment?

This critical and fatalistic outlook on the state hospitalization of the geriatric patient is contradicted by an extensive statistical review, in 1954, of geriatric in-patients in the Connecticut State Hospital System.[7] Of 4,178 patients over the age of 60

*Otto L. Bettag, M.D., director of the Illinois Department of Public Welfare.

only 231 in the study could be considered transferable, the impression being that if a geriatric patient was admitted to the state hospital he indeed needed to be there.

Metropolitan State Hospital, Norwalk.

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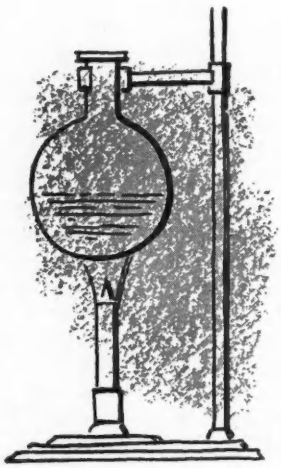


California MEDICINE

For information on preparation of manuscript, see advertising page 2

EDITORIAL

California Physician Placement Service

CURRENTLY twenty-five hundred physicians are licensed in California each year. Two thousand of them come from other states. And even this influx barely keeps pace with the explosive population increase of the state. If the current ratio of 175 physicians per 100,000 population continues, it is projected that by 1975 there will be approximately 45,000 physicians needed in California.

Programs are now being considered that will increase the number of physicians graduated by California schools. It seems unlikely, however, that these programs will fill the projected needs and therefore the influx of physicians from other states will continue at an accelerated pace.

New residents in our state need medical services. The new physician-residents need practice opportunities where their services are most needed.

From this simple bilateral need has grown the Physician Placement Service of the California Medical Association.

The formula is simple; putting the formula to work has not been quite so simple. With a modest beginning several years ago, the C.M.A. offered services to physicians seeking practice locations in California and to physicians already practicing who desired relocation opportunities, associates, partners or *locum tenens*.

With the continued increase in the number of physicians coming into the state, with new communities seeking physicians and many other factors, the Physician Placement Service has continued to expand its operation.

Each month a bulletin is published in which members of C.M.A. may list their needs for associates, partners, replacements and *locum tenens*. The listings include openings in almost every field and category of the practice of medicine. If a member has need for this service, he has only to make that need known to the Placement Service.* The Service will reply to the inquiry with a questionnaire to be filled out and returned. The information in this questionnaire is distilled into a descriptive paragraph that appears in the next issue of the bulletin.

The bulletin, *Opportunities for Practice in California* is sent to approximately 1,500 physicians monthly, including newly licensed physicians, physicians of California who wish to relocate, physicians from other states and countries who wish to come to California to practice, and others. In addition, the bulletin is sent to hospitals that conduct intern and residency programs. The interested physician makes his contact directly with the individual making the listing. The Placement Service makes no attempt to "match" applicant with opportunity.

Communities in need of physicians also list their needs in the bulletin. For new towns and especially those in the rural areas, the availability or unavailability of a physician may alter the entire economy and well-being of the community. With a physician, the area may be self-sufficient and its citizens may count on professional care when it is needed. The same community, without a physician, may find that its residents have to travel many miles and expend an undue amount of time and effort to secure even the most rudimentary medical services.

The Physician Placement Service does not limit its activities to publishing the *Opportunities for Practice* bulletin. The staff is available for personal interviews. With many younger physicians the matter of part-time employment is of importance. Many other items of interest revolve around social, educational, recreational and other needs of physicians seeking locations. Does the community have adequate schools for the physician's children? Are there cultural activities for the physician and his family?

*Physician Placement Service, 693 Sutter Street, San Francisco 2.

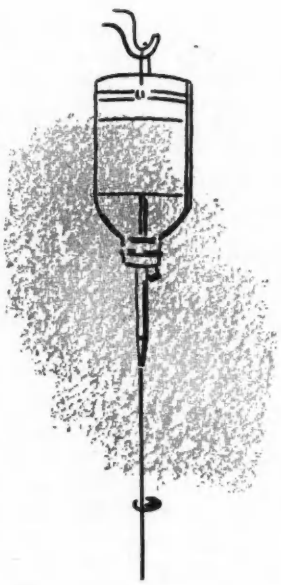
How about recreation? How about professional fellowship and availability?

These questions may seem of minor order, but in fact they are not. The physician who has spent years in the educational process is not eager to take his children into an educationally barren area. The wife who is accustomed to social and cultural activities may turn down a community where medical practice opportunities are favorable but community facilities do not meet her standards. The physician whose hobby is sailing is not likely to choose an inland community as his abode.

Several research projects are now under consideration to find ways of improving the service to physicians and communities.

This operation makes a modest dent in the budget of the California Medical Association. It does cost money to maintain a two-person staff, to collect vital information and to disseminate it to interested parties. But this cost, in terms of service to the public and to the medical profession, is minuscule. It is on the basis of this philosophy that no fees are charged to those using the Service.

The placement of physicians, to be done with objectivity and fairness to all, can best be done within the structure of organized medicine itself. The C.M.A. is doing just this. Here is one field where the public and the professional interests are identical and where medicine can perform a useful and valuable public service.



California MEDICAL ASSOCIATION

NOTICES & REPORTS

Council Meeting Minutes

Tentative Draft: Minutes of the 465th Meeting of the Council, San Francisco, Hilton Inn, January 28, 1961.

The meeting was called to order in the Hilton Inn, San Francisco International Airport, by the Chairman, on Saturday, January 28, 1961, at 9:30 a.m.

Roll Call:

Present were President Foster, President-Elect Bostick, Editor Wilbur, Speaker Doyle, Vice-Speaker Heron and Councilors MacLaggan, Wheeler, Todd, Quinn, O'Neill, Kirchner, O'Connor, Shaw, Rogers, Dalton, Murray, Davis, Miller, Sherman, Campbell, Morrison, Anderson and Teall. Absent for illness, Secretary Hosmer.

Quorum present and acting.

Present by invitation were Messrs. Hunton, Thomas, Clancy, Collins, Marvin, Whelan, Klutch, Edwards, Tobitt and Drs. Batchelder and Miller of C.M.A. staff; Messrs, Hassard and Huber, legal counsel; Messrs. Read, Salisbury and Fraser of the Public Health League of California; county executives Scheuber of Alameda-Contra Costa, Blankfort of Marin, Lingerfelt of Fresno, Field of Los Angeles, Grove of Monterey, Somerville of Napa, Bannister of Orange, Brayer of Riverside, Donmyer of San Bernardino, Nute of San Diego, Neick of San Francisco, Thompson and Pearce of San Joaquin, Wood of San Mateo, Donovan of Santa Clara, Funk of Solano, Brown of Sonoma and Bailey of Tulare; Dr. Malcolm Merrill of the State Department of Public Health; Dr. Walter Rapaport of the State Department of Mental Hygiene; Mrs. Eunice Evans of the State Department of Social Welfare; Messrs. Aubrey Gates and Richard Philleo of the American Medical Association; Messrs. Paolini, Nyron, Heller and Lyon of California Physicians' Service; Doctors Werner Hoyt, Donald Harrington, Dan O. Kilroy, Thomas Elmendorf, Rex Whitworth and others.

1. *Minutes for Approval:*

On motion duly made and seconded, several amendments to the tentative draft of the minutes of the Council meeting held December 10 and 11, 1960, were adopted and the minutes as amended were approved. [Approved version was published in CALIFORNIA MEDICINE, February, 1961.]

2. *Membership:*

(a) A report of membership as of January 26, 1961, was presented and ordered filed.

(b) On motion duly made and seconded, seven delinquent members who had regained active membership in their county societies were voted reinstatement.

(c) On motion duly made and seconded in each instance, three applicants were voted Associate Membership. These were: Carl J. Lutt, Alameda-Contra Costa County; Thomas Arthur Morrison, San Diego County; Lillian Cottrell, Sonoma County.

(d) On motion duly made and seconded in each instance, 17 members were voted Retired Membership. These were: Douglas Stafford, Alameda-Contra Costa County; Philip Hodgkin, Imperial County; Albert Allen, Lucile R. Anderson, Joseph T. Edward, Frank Edison Long, Seth H. Miles, W. G. Scanlon, Erwin Edward Stephens, Albert Valensi, Los Angeles County; A. N. Crain, Orange County; James F.

Churchill, John Eugene Porter, San Diego County; Hans Esberg, Alice Bepler O'Brien, J. Floyd Runner, Russell C. Ryan, San Francisco County.

On motion duly made and seconded, reductions in dues were voted for 23 members for reasons of illness or postgraduate study.

3. *Financial:*

(a) Chairman Heron of the Finance Committee submitted balance sheets as of December 31, 1960, for the Association and four allied organizations, Trustees of the C.M.A., Physicians Benevolence Fund, Audio-Digest Foundation and Pacific Magnetic Tape Equipment Co. These were reviewed and ordered filed.

(b) A retirement program for employees of the Association, previously approved by the Council, was submitted in detail. Estimated cost for the balance of the current fiscal year was $17,801, which, on motion duly made and seconded, was appropriated by unanimous vote.

(c) On motion duly made and seconded, and on recommendation of the committee, it was voted to reimburse three medical school deans for their expenses in attending meetings in Chicago and Washington in behalf of the Association's educational programs, expenses to come from currently budgeted and available funds.

(d) The Council accepted with thanks the check for $992.50 from Delta Blood Bank, Stockton, representing final repayment on a loan of $36,500 advanced in 1954.

4. *State Department of Public Health:*

Dr. Malcolm Merrill, State Director of Public Health, reported that the first human death from rabies in a number of years had occurred in Imperial County, on the Arizona border. Death resulted from a dog bite and following a course of 14 treatments using duck embryo vaccine.

Dr. Merrill also reviewed the budget submitted by his department for the 1962 fiscal year.

5. *State Department of Mental Hygiene:*

Dr. Walter Rapaport, representing the State Department of Mental Hygiene, reviewed some of the recommendations added to the proposed basic budget of the department. These would call for the establishment of "day hospitals" for daytime care of mental patients, for authority to place patients in private hospitals and rest homes, authority to place patients in private homes and for broadening of the Short-Doyle Act for added care in home areas for mental patients. All are designed, he reported, to eliminate the need for further construction of large state hospitals.

6. *State Department of Social Welfare:*

Mrs. Eunice Evans of the State Department of Social Welfare reported that plans have been completed for participation in the Kerr-Mills legislation to provide added medical services to the aged. A new drug formulary, listing drugs which may be prescribed without limitation, those which are limited by diagnosis and those limited by wholesale price, has been issued. Health evaluation examinations, she reported, will start April 1 for old age assistance applicants between ages 65 and 70. The department will also bring additional benefits for the blind into the present program.

Mrs. Evans reported on several legislative proposals advanced by the department. These will include legislation for matching funds to implement the second stage of the Kerr-Mills Bill, an increase in the maximum allowable pension to aged and blind recipients to provide additional care, tying in benefits with the cost of living index, liberalizing the relatives' responsibility laws and a proposed measure to provide funds on a matching basis for the establishment of local demonstration projects such as senior centers, delivered meals, etc.

7. *Medical Education:*

The chairman read a letter from Dr. J. B. deC. M. Saunders, dean of the University of California School of Medicine, in which he expressed concern over the possible production of poorly qualified physicians under several proposals which have been advanced for the establishment of new medical schools in California. On motion duly made and seconded, it was voted to refer this matter to the Commission on Medical Education for study and suggestions.

On motion duly made and seconded, it was voted to reaffirm a decision of the House of Delegates expressing approval of the establishment of a medical school in the San Diego area.

8. *White House Conference on the Aging:*

Reports were made by Doctors Foster, Sherman and Batchelder on the White House Conference on the Aging, held early in January. On motion duly made and seconded, it was voted that the Committee for Emergency Action, together with the chairmen of the public relations and legislative committees and the delegation to the American Medical Association review the status of the medical profession in the eyes of the public and develop suggestions for bringing about an improvement.

9. *Bureau of Research and Planning:*

Chairman Werner Hoyt of the Bureau of Research and Planning gave an historical and progress report for the bureau and presented a list of proposed research studies which had been assigned a priority

rating by the bureau. On motion duly made and seconded, it was voted to approve the priority listings proposed.

Dr. Hoyt left with the Council the question of the Council's determination as to how far the bureau should proceed in initiating policy for the Association. The chairman suggested that this topic be discussed in detail at the March meeting.

The Council approved a report of the Bureau of Research & Planning, "The Role of Government in Medical Care," with slight amendments and ordered that widespread publicity be given this report.

10. *Public Relations:*

Councilor Quinn and Mr. Ed Clancy reported on a meeting held with representatives of allied organizations. Mr. Clancy also reported on a meeting held with county society representatives on January 7, at which a number of local projects to enhance public relations had been described and discussed.

On motion duly made and seconded, it was voted that the Committee on Public Relations be requested to submit to an early meeting of the Council a complete report on the public relations program, finances and objectives.

11. *Committee on Legislation:*

(a) Chairman Dan O. Kilroy, chairman of the Commission on Public Policy, reported that the commission had reviewed a proposed organization which would bring together several professional groups and had been divided on the question of formation of a similar organization in California. It was agreed that the commission should assemble a list of professional organizations in California and determine all areas of mutual or overlapping interest, so that a future report may be made to the Council for further consideration.

(b) Mr. Ben Read reported that 1,260 legislative bills had been introduced in the first 28 days of the legislative session and that 192 of these have some bearing on the public health or the practice of medicine. On motion duly made and seconded, it was voted to oppose two measures, one which would establish a state system of compulsory health insurance and one which would require state licensure for x-ray technicians.

On motion duly made and seconded, it was voted that the committee, in association with the Committee for Emergency Action, prepare a statement of the Association's position on the compulsory health insurance legislation.

12. *Commission on Medical Services:*

Dr. Donald Harrington, chairman, reported for the Commission on Medical Services, the report recommending that all county societies activate or establish mediation committees to review fee complaints, including those brought by insurance carriers, and that the Association establish a statewide mediation committee to coordinate and reinforce the county committees. On motion duly made and seconded, it was voted to approve these proposals in principle and to refer to the Committee on Committees the integration of such a statewide committee into the organization structure.

The Commission also reported that it was believed impossible at this time to effectuate a system of regional professional fees for services under state medical care programs. On motion duly made and seconded, it was voted to refer this subject to the Committee for Emergency Action.

13. *Committee on Committees:*

Chairman Bostick of the Committee on Committees recommended that the present liaison committee between the Commission on Medical Services and California Physicians' Service be expanded by the addition of two members and that the committee henceforth be a direct committee of the Council. He also recommended that a second committee be formed to activate policy decisions reached between the Council and the Trustees of California Physicians' Service. On motion duly made and seconded, these recommendations were approved and Doctors Donald Harrington and Carl Anderson were added to the liaison committee.

14. *1961 Annual Session:*

Speaker Doyle of the House of Delegates outlined the plans for the meetings of the 1961 House of Delegates, reporting that meetings would be held Saturday afternoon, Sunday morning, Tuesday afternoon and Wednesday morning. On motion duly made and seconded, this schedule was approved. Proposed seating arrangements in the House of Delegates, with alternates to be seated with delegates, were also approved.

On motion duly made and seconded, it was voted that for the dinner to honor the Presidents of the Association and the Woman's Auxiliary, a reception for invited guests be held for one hour and a social hour for all those attending the dinner be held at another hour, the cost of the dinner tickets to include the social hour.

15. *Rehabilitation Services:*

Councilor Anderson presented a resolution calling attention to the establishment of in-patient rehabilitation services for Old Age Assistance recipients and requesting that the State Department of Social Welfare modify its regulations to allow the appointments within each county of qualified medical consultants who should be authorized to rule upon the

removal of such patients to distant facilities for evaluation and treatment. The resolution also asked that the Committee on State Medical Services be requested to review the regulations and make such other recommendations as might be indicated. On motion duly made and seconded, this resolution was approved.

16. *Committee on Maternal and Child Care:*

Dr. Rex Whitworth requested authority for the Committee on Maternal and Child Care, through its subcommittee on perinatal mortality and morbidity, to undertake studies of hemolytic disease of the newborn in conjunction with the State Department of Public Health. It was brought out that similar studies are being undertaken by other agencies and that duplication should be avoided. On motion duly made and seconded, it was voted to refer this proposal to the Committee on Committees for further study and recommendation.

17. *California Physicians' Service:*

Dr. John Morrison reported that the ad hoc committee to study the MD-65 program of California Physicians' Service had recommended that payments to physicians be placed on a factor 4 basis and that further enrollments in this program be discontinued at this time. On motion duly made and seconded, these recommendations were approved.

The Council also approved in principle several proposals of the ad hoc committee which would expand the benefits of the MD-65 program by adding hospitalization and other benefits. These proposals are to be reported to the C.P.S. Board of Trustees and reported later to the Council.

Dr. Morrison also reported that following meetings with the Committee on Fees, two new schedules for C.P.S., schedule "D" and schedule "E," had been approved, based on factors 5 and 6, respectively, on the 1960 Relative Value Studies. These factors would cover all sections of the studies and be subject to later application of variable factors as between the sections, as determined by the Committee on Fees.

18. *Committee on Industrial Health:*

Dr. MacLaggan presented the recommendation of the Committee on Industrial Health for renewed attempts to secure more equitable fees for industrial injury services. It was pointed out that adjustments in such fees require considerable time and that policy has been to reopen this matter about each two years.

The committee also requested that its name be changed to "Committee on Occupational Health." Such a change would require an amendment to the By-Laws.

19. *Commission on Professional Welfare:*

Chairman Kirchner of the Commission on Professional Welfare called attention to a regional conference on medical-legal matters to be sponsored by the American Medical Association in San Francisco on March 10 and 11. The Commission requested authority to provide a reception for this gathering on March 10 and, on motion duly made and seconded, such authority was voted.

Dr. Kirchner also announced that the underwriters of the Association's disability insurance contract had agreed that cash dividends would be paid late in the year to members who are currently covered and who have participated in the plan in the past.

Adjournment:

After a brief period of executive session and there being no further business to come before it, the meeting was adjourned at 6:30 p.m.

SAMUEL R. SHERMAN, M.D., *Chairman*
JOHN HUNTON, *Acting Secretary*

4 POSTGRADUATE COURSES

C.M.A. ANNUAL SESSION • *April 29–May 3, 1961* • *Los Angeles*

THE CALIFORNIA MEDICAL ASSOCIATION *in cooperation with the Medical Schools of* UNIVERSITY OF SOUTHERN CALIFORNIA *and* COLLEGE OF MEDICAL EVANGELISTS, *will present four Postgraduate Courses at the time of the Annual Session in April. These courses will be clinically oriented and will include case presentations.*

Choose the course which most interests you, follow the course, and the 1961 session will send you back to your practice stimulated and refreshed.

Look for the program giving complete details which will arrive in your office in March.

• By COLLEGE OF MEDICAL EVANGELISTS

Clinical Neurology—9 hours

Time: Sunday, April 30, 9:00 a.m. to 12:00 noon; Monday and Tuesday, May 1 and 2, 2:00 p.m. to 5:00 p.m.

Place: White Memorial Hospital. *Fee:* $25.00

• By UNIVERSITY OF SOUTHERN CALIFORNIA

Uses and Limitations of Laboratory Tests—9 hours

Time: Saturday, April 29, 9:00 a.m. to 12:00 noon; 1:30 p.m. to 5:00 p.m.; Sunday, April 30, 9:00 a.m. to 12:00 noon.

Place: Los Angeles County Hospital. *Fee:* $25.00

Practical Gynecology—9 hours

Time: Saturday, April 29, 9:00 a.m. to 12:00 noon; 1:30 p.m. to 5:00 p.m.; Sunday, April 30, 9:00 a.m. to 12:00 noon.

Place: USC School of Medicine. *Fee:* $25.00

Cardiac Resuscitation—2 hours

SECTION I*—Saturday, April 29, 9:00 a.m. to 11:00 a.m.

SECTION II*—Sunday, April 30, 2:00 p.m. to 4:00 p.m.

Place: USC School of Medicine. *Fee:* $30.00

*Each Section is all-inclusive. Each Section is limited to 15 registrants from areas other than San Francisco or Los Angeles.

APPLICATION FOR ENROLLMENT

Mail to: POSTGRADUATE ACTIVITIES, CALIFORNIA MEDICAL ASSOCIATION
2975 Wilshire Boulevard, Los Angeles 5, California

With check or money order in the amount of $_____ made payable to *California Medical Association*

Name_____

Address_____

I am in General Practice_____ I limit my practice to_____

Medical School Attended_____ Year of Graduation_____

Please enroll me in the course indicated by ✓.

☐ 1. **Clinical Neurology** (9-hour course, Sunday morning; Monday and Tuesday afternoons)—$25.00

☐ 2. **Uses and Limitations of Laboratory Tests** (9-hour course, Saturday, all day; Sunday morning)—$25.00

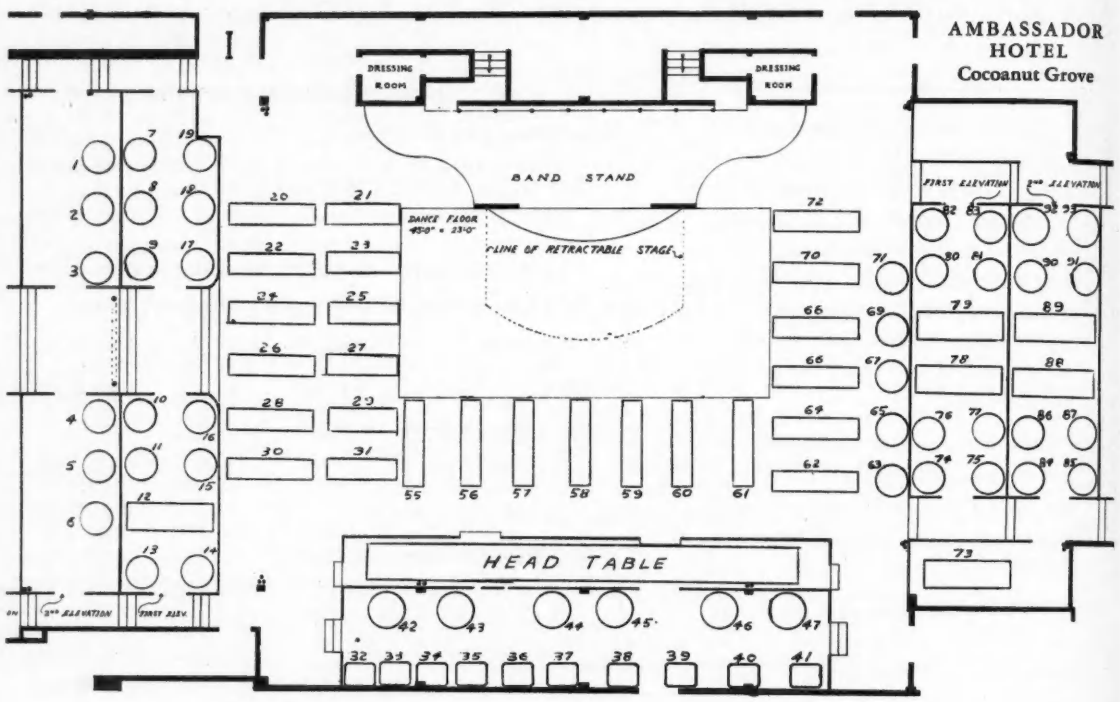
☐ 3. **Office Gynecology** (9-hour course, Saturday, all day; Sunday morning)—$25.00

☐ 4a. **Cardiac Resuscitation—Section I**—Saturday morning—$30.00

☐ 4b. **Cardiac Resuscitation—Section II**—Sunday afternoon—$30.00

COME to the...

ANNUAL SESSION



Choose the location of your table from the floor plan above. The corresponding table number below gives the number of seats at each table. Please fill out coupon on opposite page.

Table Number	Number of Seats	Table Number	Number of Seats	Table Number	Number of Seats	Table Number	Number of Seats	Table Number	Number of Seats
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6	4	24	10	41	2	66	12	83	6
7	4	25	10	42	8	67	4	84	4
8	4	26	10	43	8	68	12	85	6
9	4	27	10	44	8	69	4	86	6
10	4	28	10	45	8	70	12	87	4
11	4	29	10	46	8	71	4	88	12
12	12	30	10	47	8	72	12	89	12
13	4	31	10	55	12	73	10	90	6
14	4	32	2	56	12	74	4	91	4
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GO to the...

Presidents' Dinner-Dance

SUNDAY, APRIL 30, 8 p.m.

Cocoanut Grove

Reception: EMBASSY ROOM—7 p.m. to 8 p.m.

Entertainment

Music for Dancing

Food: Prime Rib Dinner

Cost: $15.00 per person including reception, tax, tip and cover

TICKETS ARE NOW ON SALE—USE COUPON BELOW

Your tickets will be held for you at the door to the Embassy Room. A receipt for your check will be sent to you. Please present this receipt at the door for your ticket, Sunday night.

OR

Tickets may be picked up at any time Sunday morning or afternoon, April 30, at ticket booth, Woman's Auxiliary registration desk. Requests for tables for large parties should be sent in one envelope and early.

MISS LOUISE KALINICH
Los Angeles County Medical Association
1925 Wilshire Boulevard
Los Angeles 57, California

Enclosed is my check for $_____. Please send me _____ ticket(s) to the PRESIDENTS' DINNER-DANCE, Sunday, April 30, 1961.

Table Choice _____ _____ _____ —or assign next best available _____
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Name _____

Address _____

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(Make checks payable to the California Medical Association)

11th ANNUAL

REGIONAL POSTGRADUATE INSTITUTE

SAN JOAQUIN VALLEY COUNTIES

Presented by the California Medical Association Committee on Postgraduate Activities, in cooperation with Fresno, Madera, Kings, Tulare, Kern, Merced-Mariposa, Inyo-Mono and Stanislaus County Medical Societies and the Department of Continuing Education in Medicine and Health Sciences, University of California Medical Center, Los Angeles, Thomas H. Sternberg, M.D., Assistant Dean, Department of Continuing Education in Medicine and Health Sciences.

Guest Speaker: JOHN M. KINNEY, M.D., Associate in Surgery, Harvard Medical School at Peter Bent Brigham Hospital, Boston.

Ahwahnee Hotel, Yosemite National Park

April 14 and 15, 1961

PROGRAM

FRIDAY, APRIL 14

Morning Meetings

THE ACUTE ABDOMEN

9:15-10:00—**Medical Aspects**—John C. Sharpe, M.D.

10:00-10:45—**Electrolyte Problems—Pre- and Postoperative**—John M. Kinney, M.D.

11:00-11:45—**Surgical Aspects**—Wiley F. Barker, M.D.

11:45-12:15—**Panel Discussion**—Wiley F. Barker, M.D., John M. Kinney, M.D., John C. Sharpe, M.D.

Afternoon Meetings

2:00-2:45—**Autoimmune Diseases**—Victor D. Newcomer, M.D., Carl M. Pearson, M.D.

2:45-3:30—**Virus Diseases—Diagnosis and Management**—John M. Adams, M.D.

3:45-5:00—**BLOOD TRANSFUSIONS:**

Uses and Abuses—Wiley F. Barker, M.D.

Problems of Multiple Transfusions—John B. Dillon, M.D.

Uses of Blood and Blood Fractions from the Los Angeles Red Cross Blood Center—Eugene P. Adashek, M.D.

ELECTIVES

2:00-2:45—**Newer Aspects of Hand Surgery**—Franklin L. Ashley, M.D.

2:45-3:30—**Recurrent Abdominal Pain in Children**—Harry F. Dietrich, M.D.

7:00-8:00—**"No-Host" Cocktail Party.**

8:00—**Dinner-Dance.**

SATURDAY, APRIL 15

Morning Meetings

MANAGEMENT OF TRAUMA

9:15-9:55—**General Principles**—Wiley F. Barker, M.D.

9:55-10:35—**Resuscitation**—John B. Dillon, M.D.

10:50-11:30—**Maxillo-Facial Injuries**—Franklin L. Ashley, M.D.

11:30-12:15—**Panel Discussion**—Moderator: Wiley F. Barker, M.D.; Panel: Franklin L. Ashley, M.D., Eugene P. Adashek, M.D., John B. Dillon, M.D., John M. Kinney, M.D.

ELECTIVES

10:50-11:30—**Laboratory Tests Useful in Rheumatoid Disease**—Carl M. Pearson, M.D.

11:30-12:15—**Current Status of Treatment of Fungi**—Victor Newcomer, M.D.

Afternoon Meetings

2:00-2:45—**Diagnostic and Immunization Procedures in Childhood**—John M. Adams, M.D., Harry F. Dietrich, M.D.

3:00-3:45—**What Is an Adequate Physical Examination**—John C. Sharpe, M.D.

3:45-5:00—**Skin Tumor Clinic**—Franklin L. Ashley, M.D., Victor D. Newcomer, M.D.

ELECTIVE

2:00-2:45—**Medical Diseases of the Back**—Carl M. Pearson, M.D.

HOST: Fresno County Medical Society . . . **REGIONAL CHAIRMAN:** J. Malcolm Masten, M.D., 1051 R Street, Fresno, California . . . **INSTITUTE FEE:** $15.00. For additional information contact Postgraduate Activities office, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5. **All California Medical Association members and their families are cordially invited to attend.**

In Memoriam

ADLER, MURRAY LAURENCE. Died October 26, 1960, aged 44, of coronary thrombosis. Graduate of New York Medical College, Flower and Fifth Avenue Hospitals, New York, 1947. Licensed in California in 1955. Doctor Adler was a member of the Los Angeles County Medical Association.

✤

BARTHOLOMEW, TRUMAN EMORY. Died in Tulare, February 4, 1961, aged 65, of heart disease. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1928. Licensed in California in 1928. Doctor Bartholomew was a member of the Tulare County Medical Society.

✤

BERGMAN, MACKS LEONARD. Died in Inglewood, December 18, 1960, aged 52, of a coronary. Graduate of the University of Vermont College of Medicine, Burlington, 1936. Licensed in California in 1945. Doctor Bergman was a member of the Los Angeles County Medical Association.

✤

CHRISTENSEN, WILLIAM MELVIN. Died in Glendale, January 21, 1961, aged 66. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1924. Licensed in California in 1924. Doctor Christensen was a member of the Los Angeles County Medical Association.

✤

DECKER, KATHLEEN HOGAN. Died in an auto crash, January 9, 1961, aged 32. Graduate of the University of Minnesota Medical School, Minneapolis, 1954. Licensed in California in 1956. Doctor Decker was a member of the Los Angeles County Medical Association.

✤

HUNTER, WARREN ELLIS. Died January 5, 1961, aged 58. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1928. Licensed in California in 1928. Doctor Hunter was a member of the Los Angeles County Medical Association.

✤

HUNTINGTON, BERT ROY. Died January 15, 1961, aged 81. Graduate of the State University of Iowa College of Medicine, Iowa City, 1907. Licensed in California in 1925. Doctor Huntington was a member of the Los Angeles County Medical Association.

✤

KAHN, JULIUS. Died February 4, 1961, aged 65. Graduate of Rush Medical College, Chicago, Illinois, 1921. Licensed in California in 1922. Doctor Kahn was a member of the Los Angeles County Medical Association.

✤

KELLOGG, WILLIAM A. Died February 3, 1961, aged 75. Graduate of Columbia University College of Physicians and Surgeons, New York, New York, 1913. Licensed in California in 1927. Doctor Kellogg was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

LACAYO, JOSE RENATO. Died January 21, 1961, aged 64. Graduate of the University of Buffalo School of Medicine, New York, New York, 1926. Licensed in California in 1928. Doctor Lacayo was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

MILLER, NEWTON. Died in Porterville, January 7, 1961, aged 81. Graduate of Rush Medical College, Chicago, Illinois, 1924. Licensed in California in 1926. Doctor Miller was a member of the Tulare County Medical Society.

✤

MOODY, ADELBERT MONTAGUE. Died in San Francisco, January 28, 1961, aged 78. Graduate of Rush Medical College, Illinois, 1910. Licensed in California in 1923. Doctor Moody was a member of the San Francisco Medical Society.

✤

NEWTON, EARL BURDETTE. Died in Oakland, February 2, 1961, aged 77, of heart failure due to hypertensive arteriosclerotic cardiovascular disease with congestive failure. Graduate of the Stanford University School of Medicine, Stanford-San Francisco, 1922. Licensed in California in 1922. Doctor Newton was a retired member of the Alameda-Contra Costa Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

ROYER, J. ELLIOTT (JESSE). Died in Belmont, January 7, 1961, aged 79, of cerebral arteriosclerosis. Graduate of the University Medical College of Kansas City, Missouri, 1907. Licensed in California in 1925. Doctor Royer was a retired member of the Alameda-Contra Costa Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

RUSSELL, RILEY. Died January 27, 1961, aged 85. Graduate of the George Washington University School of Medicine, Washington, D. C., 1908. Licensed in California in 1922. Doctor Russell was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

SKELTON, LEONARD W. Died in San Marino, January 23, 1961, aged 64. Graduate of the University of California School of Medicine, Berkeley-San Francisco, 1924. Licensed in California in 1924. Doctor Skelton was a member of the Los Angeles County Medical Association.

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STOCK, GEORGE E., JR. Died February 3, 1961, aged 46. Graduate of New York University College of Medicine, New York, 1940. Licensed in California in 1947. Doctor Stock was a member of the San Diego County Medical Society.

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THOMPSON, ROBERT HOFER. Died January 29, 1961, aged 57. Graduate of the University of Oregon Medical School, Portland, 1931. Licensed in California in 1931. Doctor Thompson was a member of the Los Angeles County Medical Association.

✤

TURNBULL, FREDERICK MYLES. Died January 13, 1961, aged 75. Graduate of McGill University Faculty of Medicine, Montreal, Quebec, 1909. Licensed in California in 1926. Doctor Turnbull was a member of the Los Angeles County Medical Association.

PUBLIC HEALTH REPORT

MALCOLM H. MERRILL, *M.D., M.P.H.*
Director, State Department of Public Health

NO OUTBREAKS or laboratory confirmed individual cases of influenza have been reported in California since the termination of the epidemic of influenza which occurred about a year ago.

The U. S. Communicable Disease Center reports that the situation is similar throughout the nation, with only sporadic reports of laboratory confirmed cases of Influenza A having come to its attention.

The department's Influenza Surveillance Unit is again using a variety of public and private agencies as listening posts to detect early occurrence of influenza and influenza-like illnesses in the community.

The surveillance network reports the following: School absenteeism, which involves the observation of some 100,000 children, is running at the normal expected rate of 6 to 8 per cent; employee absenteeism at several industrial plants and public agencies is normal and without any unusual absenteeism reported so far this year; reports of respiratory illness among various population groups, and including institutions and hospitals, show no indication of unseasonal increases in influenza-like illness.

The department recommends routine annual immunization of persons at all ages who suffer from chronic debilitating disease; also pregnant women, and all persons 65 years of age and older. The commercially available influenza vaccine is an aqueous, polyvalent preparation containing three strains of Type A and one strain of Type B killed influenza virus and is produced with the same composition by several manufacturers.

* * *

Survival rates for patients with cancer have been computed by the department through 237 billion arithmetic calculations on electronic data processing machines.

The tabulations, performed by the Bureau of Vital Statistics and Data Processing, describe survival rates by patient age and sites of cancer among the 110,000 cases of neoplasm in the California Tumor Registry. The information will be published late this year in a monograph, "Cancer Registration and Survival in California."

* * *

The Los Angeles City Health Department has joined a nationwide U. S. Public Health Service study to evaluate the effectiveness of INH (isonicotinic acid hydrazide) in preventing reactivation of tuberculous disease.

Selected patients with inactive tuberculosis will be given INH for one year. They will be evaluated by x-ray examination at the end of the year and then annually for several years. Individual reports will be combined with those from other areas in the nation to determine whether reactivation of disease can be prevented.

If INH prophylaxis proves successful for this group of patients, a powerful technique will be added to aid in the eradication of tuberculosis. Previous studies using the drug have shown that children can be protected from many of the complications of primary tuberculosis.

* * *

A training plan for nursing home administrators as a step toward improvement of patient care has been initiated by the State Health Department in a contract with the Attending Staff Association of Rancho Los Amigos Hospital, Los Angeles.

* * *

Oxides of nitrogen concentrations of over 3.0 parts per million in the atmosphere have been measured in Los Angeles on two recent occasions. A value of 3.0 ppm represents that district's "first alert" level, and marks the first instances in which air pollutants other than ozone have reached the Los Angeles first alert values.

The concentrations were not considered to present a danger to the public health. However, they are very high values for the atmosphere of communities and present a number of important problems. Since these concentrations are already high, there is concern over further increases. In addition to the concern over oxides of nitrogen because of toxic effects, these compounds at present concentration levels react in the atmosphere with hydrocarbons to produce smog.

Oxides of nitrogen are produced from combustion sources. Motor vehicle exhaust is one of the most important of these. It has been estimated that motor vehicles contribute more than half of all the oxides of nitrogen found in the Los Angeles atmosphere.

Letters to the Editor...

Children, the Victims of Fragmentation Of Health Services

CHILDREN are important. They are the men and women of tomorrow. Their physical, mental, and emotional well-being is the responsibility of the medical and allied professions. There is a great deal of money, public (federal, state, and local) and private, (a charity fund for every day of the year) expended and yet it is practically impossible to finance adequately simple programs of child care. The delinquency rate, the neurotic and psychotic statistics, indicate that such programming is important and should be supported.

At the end of World War II the Academy of Pediatrics sponsored a nationwide study of health services for children. I participated in the study and for several years thereafter attended national committee meetings concerned with medical education leading to better child health care. For the past 10 to 15 years as Chief of Pediatrics at Children's Hospital I have tried to analyze the nearly insurmountable problems encountered in programming for children in need of special help. This communication is an attempt to record the findings of this study. Three different groups of children will be briefly reviewed: (1) The handicapped child, (2) the deprived child, and (3) the health problems of the normal child.

The Handicapped Child

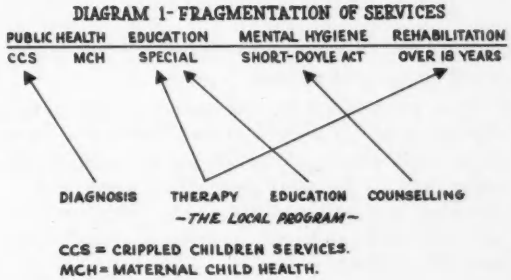
Children with a chronic or longterm handicap such as central nervous system disease, blindness, deafness, cardiac anomalies, metabolic diseases, congenital defects, etc., need planning, as follows: (a) diagnosis, (b) therapy, (c) education, and (d) counseling. The planning and staffing for this type of program is not difficult nor unduly expensive, especially if the preventive aspects of such programming are considered. The financing and the execution of the program is well nigh impossible. Diagram 1 is an attempt to clarify the reasons. Money for diagnosis of some diseases can be obtained through Crippled Children Services. The C.C.S., however, has grown haphazardly and new diseases have been added without overall planning. This leads to some difficulty. The Crippled Children Services should be reviewed and the diseases coming under their jurisdiction reevaluated. This should not be too difficult a procedure and certainly calls for pediatric participation in any such reevaluation.

Diagnosis, however, is the easiest part of the problem. When therapy is contemplated the Crippled Children Services give very little direct assistance except for surgical procedures. The daily therapy, for instance, of the cerebral palsy child is administered only through the school system and the financing comes down through the Department of Education. Crippled Children Services can participate in therapy for the cerebral palsy child only through this system. The clinics for the cerebral palsy child are set up in the School Department. Originally these clinics were conducted by orthopedists and to a large extent they still are so conducted. It a patient has minimal motor involvement but a learning problem such as an expressive aphasia, he is not eligible for such a clinic. If he is too handicapped to be educable, he has no choice for therapy except through the school clinic. As the crippling problems became recognized earlier in the child's life, schooling was pushed back to accommodate the kindergarten children and then the nursery school children. Now that these conditions are often recognized at birth or shortly thereafter, these babies have to go to the school clinic to get any help and usually the type of help that is given in the school clinic is not either what the child or the parents need.

Legislation for day care for the severely handicapped uneducable child is also in the hands of the Department of Education. This group of children need nursing care as they are untrained, they are not educable and usually not trainable, they are subject to convulsions. Physiotherapy and occupational therapy will help them some but mostly they present a problem of day custodial care. It is "baby-sitting" and educators should spend their time at something besides baby-sitting. These day care centers should be under pediatric supervision and associated with hospitals.

The education and training of the handicapped child is also exclusively in the hands of the educators. There are state schools for cerebral palsy, the blind, and the deaf; there are local schools for children with motor handicaps; there are schools and classes for the deaf, the blind, and the retarded. The function of each of these schools is clearly defined

DIAGRAM 1- FRAGMENTATION OF SERVICES



CCS = CRIPPLED CHILDREN SERVICES.
MCH = MATERNAL CHILD HEALTH.

and limited. The admission, retention, or expulsion of a pupil is under the control exclusively of the educators.

A handicapped child rarely escapes with only one handicap. There is no provision made for a cerebral palsy child who is blind and/or deaf. The deaf school will not take him; the blind school will not; and the cerebral palsy school will not accept him. The same applies to a hyperkinetic child with or without retardation. A similar policy is practiced in the state school for these handicaps.

A handicapped child needs repeated evaluation and the parents need counseling. This calls for the services of psychologists and social workers. State money for such services comes through the Mental Hygiene Division, more particularly the Short-Doyle Act. Again, these funds are so delimited and their use so defined that it has been impossible to utilize these monies for help for either the handicapped or retarded in the program.

The rehabilitation services of the state, again a separate department, are limited primarily to adults over 18.

The private charity fund drives raise a tremendous amount of money and our people are willing to give to these funds. Again, each charity clearly defines its function. It will support only its own specific disease and only in its own prescribed manner. The result is that children in need of help either fall between the charities or their heads fall in one classification and their feet in another. The charity table is heaped with good intentions but the children and the programs aimed at helping these children get only the crumbs that fall from this table.

A possible solution to the above fragmentation at the state level would be removal of the children from all of these divisions and the creation of a special department for the handicapped child. This naturally should be in the Department of Health with a pediatrician in charge. Members of the other divisions, namely, Education, Mental Hygiene, and Rehabilitation, should work in close cooperation but be ancillary to the pediatrician in charge of such a division.

At the local level the programming and habilitation for these services should be in hospitals, again, under pediatric supervision. The clinics should be removed from schools where they do not belong and placed in hospital settings.

Those in charge of the charity funds should make a determined effort to look at the children and their needs and support these programs accordingly rather than by the sharp delineation which is now practiced. It would be timely also to determine how much of these funds are "consumed" before they reach the children.

The Deprived Child

The Public Welfare Department has a division known as Aid to Needy Children (A.N.C.). This aid, however, includes the parents, primarily the mother, of the needy child. The medical program, probably in part to economize by utilizing existing facilities but also possibly in order to please the private physician, was set up as follows: (1) Well child care was to be obtained through the existing well baby clinics; (2) hospitalization, when necessary, was delegated to the county hospital; (3) private physicians would be paid for making home calls on the sick. The result of this program is a discontinuity of care that baffles the patient and has completely discouraged the physician. The private physician can treat an A.N.C. child for diabetes but if that child gets a severe infection or goes into diabetic coma he is sent to the county hospital to be treated by a new set of doctors. Pediatricians have told tales of how after a diagnosis of acute appendicitis or pneumonia the child was sent to the county hospital only to be sent home with the statement that he was eligible for private care. These tales are innumerable.

In order to eliminate some of this fragmentation a group of pediatricians, after meeting and discussing the problem, suggested the following, namely, that well child and routine care be in existing hospital clinics, including the well baby clinic in the hospital. This same hospital should then be utilized for any illnesses of the patients registered with them. A group of staff physicians would volunteer to make home calls on patients so registered. This suggestion has been sent to the local county medical society and to the community chest.

The Normal Child

Practically all specialties in medicine see children in some capacity and yet most of the physicians in specialties other than pediatrics have had little or no training in childhood diseases or with children per se beyond that given in undergraduate medicine. There is now a tendency to have straight internships and even in many rotating internships pediatrics is reduced to one month. This lack of training in the characteristics of the young has serious implications. The toxicity of drugs is not sufficiently tested for the young with consequences such as blindness from excess oxygen, gray baby deaths from chloromycetin, etc.

The hazards of radiation have been given a little more attention but this is still largely in the "lip service" stage.

Although there is an increasing number of pediatricians in the subspecialties such as allergy, metabolic diseases, cardiology, hematology, etc., these conditions are still often handled by internists who know a great deal about the disease but very little about the child, his growth, or his ego needs.

The surgical specialties are the greatest offenders. These add to the hazards of medication and emotional trauma those of anesthesia and hypoxia to the growing brain. Frequently also, because of lack of knowledge of the child, water intoxication occurs or excess blood is given. The pediatric surgeon has had a formidable struggle indeed to get recognition.

Since children are our greatest asset, the medical school should not end the study of growth of human beings with the completion of the course in embryology. Growth, development, maturation, aging, and ecology should be a basic course in the medical school continuous through the undergraduate years. Every specialty and subspecialty that deals even remotely with children should be required by their respective boards to have an intensive course in pediatrics before certification.

Although this communication deals with children, the same situation probably exists to a varying degree in all of medicine and the allied services. Is it not opportune that as physicians we take some active steps to remedy it?

H. E. THELANDER, M.D.

San Francisco

What Constitutes an Adequate Exploration in the Abdomen

NOT INFREQUENTLY exploration of the abdominal-pelvic viscera at laparotomy is an exceedingly casual affair. Two recent cases which have come to my attention, point up the necessity of carrying out the above in an orderly and detailed fashion if the patient is to receive the best we have to offer in the way of treatment when the abdominal cavity is opened. Both cases were those of intestinal bleeding in which duodenal deformities were demonstrated by x-ray. The hemorrhage was massive and the patients were explored. In neither case was the gastrointestinal bleeding from the duodenal ulcer, yet in both, definitive surgical treatment was carried out for a duodenal ulcer. In both instances the patients bled again and subsequent therapy of a surgical nature was required. In one instance a re-resection was carried out without benefit to the patient and in the other instance the patient was found to have a Meckel's diverticulum from which he was bleeding. In the first instance the patient finally succumbed to the hemorrhage and at autopsy a large gastric ulcer high in the stomach was detected which had not been demonstrated by x-ray nor had it been diagnosed at the time of exploration. These are merely two incidences which could have been eliminated had adequate exploration been carried out.

The pancreas and the adrenal glands are other structures that are often neglected during examination. Except in emergency conditions, it should be the invariable practice of all surgeons who open the abdomen, to palpate every structure within the abdominal-pelvic cavities and to record the observations in the operative notes. To complete an exploration and describe such at the end of an operation with the note, "The remainder of the abdominal exploration was negative," or to have only some abdominal viscera described in the operative note with no mention of the other organs, is poor practice and one which, unfortunately, is common today. A system for exploration should be developed by every surgeon. One method is to explore the pelvic and abdominal cavity starting at a point usually removed from the site of pathology anticipated or known pathologic condition. In dictating the operative report, every structure is described and recorded including all intraperitoneal as well as extraperitoneal organs which are palpable through abdominal incisions. This is particularly important in relation to the kidney and pancreas for routine exploration enhances one's ability to detect and distinguish diseases of the pancreas and kidney when they are present.

GORDON F. MADDING, M.D.

Burlingame

NEWS & NOTES

NATIONAL · STATE · COUNTY

LOS ANGELES

The second annual **Medical Assembly at Saint Joseph Hospital** in Burbank will be held Friday and Saturday, March 24 and 25, in the hospital auditorium. The subject for the assembly will be endocrinology.

Members of the faculty are: Gerson R. Biskind, M.D., chief of the Department of Pathology at Mount Zion Hospital in San Francisco and associate clinical professor of pathology at the University of California Medical School; Edwin H. Ellison, M.D., professor and chairman of the Department of Surgery, College of Medicine, Marquette University; Warren R. Lang, M.D., associate professor of obstetrics and gynecology, Jefferson Medical College, Philadelphia; Robert M. Blizzard, M.D., associate professor of pediatrics and chief of the division of pediatric endocrinology at Johns Hopkins University School of Medicine; and Albert Segaloff, M.D., associate professor of clinical medicine at Tulane University.

* * *

Speakers at the annual **Brennemann Lectures** of the Los Angeles Pediatric Society, to be held November 8 and 9, 1961, at the Ambassador Hotel, will be Dr. Charles A. Janeway, chairman of the Department of Pediatrics, Harvard Medical School, and Dr. Robert Blizzard, chief of pediatric endocrinology, Johns Hopkins School of Medicine.

* * *

A merger of **Cedars of Lebanon Hospital** with **Mount Sinai Hospital** was announced as officially accomplished early in February. Under the new name, Cedars of Lebanon-Mount Sinai Hospitals, the consolidated organization with combined bed capacity of 790 will continue to operate the present facilities while laying plans and seeking a site for a proposed new $50,000,000 Los Angeles Jewish Medical Center with at least a thousand beds.

Dr. Leo G. Rigler is executive director of the merged hospitals.

* * *

Dr. Catherine G. Pearson has been elected president of the **Los Angeles Society of Allergy,** Dr. Sheldon C. Siegel, vice-president, and Dr. Milton A. St. John, secretary-treasurer.

* * *

Dr. Philip B. Hartley has been elected president of the **Long Beach Obstetrical and Gynecological Society** for this year, Dr. William L. Boucher, vice-president, Dr. Donald E. King, treasurer, and Dr. Richard J. Cach, secretary.

SAN FRANCISCO

A limited number of vacancies are now available for **medical officers** in the 146th Evacuation Hospital, according to an announcement by Dr. Robert C. Combs, hospital commander. This is an opportunity for physicians who are qualified to fulfill their **military obligations,** the announcement said.

The hospital is a 400-bed semi-mobile hospital with headquarters in San Francisco. It is one of two such hospitals of the California Army National Guard. Physicians who are qualified are commissioned at the 1st lieutenant level or above, depending on age, length of practice, etc. General medicine and surgery billets are open, as well as the full range of the sub-specialties.

Further information may be obtained from the hospital, LOmbard 4-7715.

* * *

Dr. Ernest Jawaetz, professor of microbiology, University of California Medical Center, San Francisco, was elected president of the **Western Society for Clinical Research** during the meeting at Carmel in January.

* * *

The annual convention of the **National Geriatrics Society** will be held May 1 to 4, 1961, in the St. Francis Hotel, San Francisco.

* * *

Doctor L. Henry Garland, clinical professor of radiology, University of California Medical School, San Francisco, and consultant to the Cancer Research unit there, was elected president of the **American College of Radiology,** at its recent annual meeting in Chicago.

GENERAL

Appearing at the annual convention of **California Medical Assistants Association,** to be held April 15 and 16 at the Hacienda in Bakersfield, will be Dr. E. Vincent Askey, president of the American Medical Association. Dr. Ralph E. Reiner of Fresno will speak on the subject "The Medical Assistant." Dr. Steward Smith of San Diego takes the topic "This Is Your Life." Further information regarding the convention may be obtained from the executive office of the Medical Assistants Association, 693 Sutter Street, San Francisco 2.

* * *

The editors of *Modern Medical Monographs* announce the 1961 **competition for unpublished manuscripts** written by graduate physicians less than 40 years of age, on clinical subjects in the field of internal medicine. The purpose of these annual awards is to stimulate young physicians to communicate their work in the classical form of the monograph and to achieve high standards of medical writing.

The first prize is $500. In addition, the authors of other top-ranking manuscripts which are found suitable will be offered a contract for publication of their work as a book in the series *Modern Medical Monographs* under standard royalty arrangements.

Rules of the competition may be obtained from Dr. Irving S. Wright, 450 East 69th Street, New York 21.

POSTGRADUATE
EDUCATION NOTICES

THIS BULLETIN of the dates of postgraduate education programs and the meetings of various medical organizations in California is supplied by the Committee on Postgraduate Activities of the California Medical Association. In order that they may be listed here, please send communications relating to your future medical or surgical programs to Postgraduate Activities, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5.

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Clinical Traineeships — Anesthesia, Dermatology and Pediatric Cardiology. Dates by arrangement. Minimum period—two weeks. Fee: Two weeks, $150.00; four weeks, $250.00.

Management of Pain by Therapeutic Nerve Blocks —Harbor Hospital. Friday through Sunday, April 7 through 9. Eighteen hours. Fee: $55.00 (includes two luncheons).

Israel—Clinical Postgraduate Program (sessions to be held in Jerusalem and Tel Aviv). April 20 through 28. Thirty-two hours. Fee: $200.00.

Management of Trauma—Harbor Hospital. Friday and Saturday, May 19 and 20. Nine hours.*

Gerontology. Friday and Saturday, May 19 and 20. Twelve hours.*

Common Emergencies in Clinical Practice. Friday and Saturday, May 26 and 27. Twelve hours. Fee: $40.00.

Dermatology in Clinical Practice. Tuesday, July 11. Six hours. Fee: $20.00.

Advanced Seminars in Dermatology (for Dermatologists). Wednesday through Sunday, July 12 through 16. University Conference Center, Lake Arrowhead. Fourteen and one-half hours. Fee: $150.00 (includes room and meals).

Infertility. Friday and Saturday, July 14 and 15.†

Advanced Seminar on Infertility. Sunday through Wednesday, July 16 through 19. University Conference Center, Lake Arrowhead.†

General Pediatrics. Wednesday through Sunday, August 2 through 6. University Conference Center, Lake Arrowhead. Sixteen hours. Fee: $150.00 (includes room and meals).

Endocrinology. Friday and Saturday, August 4 and 5.†

For information on courses for physicians or ancillary personnel *contact:* Thomas H. Sternberg, M.D., assistant dean for Continuing Medical Education, U.C.L.A. Medical Center, Los Angeles 24. BRadshaw 2-8911, Ext. 7114.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Evening Lecture Series in Medicine, Eden Hospital. Tuesday evenings, April 4 through May 23.†

Laboratory Investigation of Endocrine Disorders. Friday through Sunday, April 7 through 9. Twenty-one hours.*

General Surgery. Thursday and Friday, April 20 and 21. Fourteen hours.*

Ear-Nose-Throat. Thursday through Saturday, May 11 through 13. Twenty-one hours.*

Proctology. Thursday and Friday, May 18 and 19. Fourteen hours.*

Water, Salts and Steroids. Thursday through Saturday, May 25-27. Twenty-one hours.*

A Course in Ophthalmology. Thursday through Saturday, June 1-3. Twenty-one hours.*

Electrocardiography. Friday and Saturday, June 9 and 10. Fourteen hours.*

A Course in Psychiatry for Physicians in General Practice. Thursday through Saturday, June 15-17. Twenty-one hours.*

Cerebral Palsy. Thursday and Friday, June 29 and 30. Fourteen hours.*

Fundamental Practices of Radioactivity and the Diagnostic and Therapeutic Uses of Radioisotopes. Two or three month course limited to one enrollee per month. Fee: $350.00.

For information on courses for physicians or ancillary personnel *contact:* Department of Continuing Medical Education, University of California Medical Center, San Francisco 22. MOntrose 4-3600, Ext. 665.

PRESBYTERIAN MEDICAL CENTER, SAN FRANCISCO

Problems in Therapy of Cardiac Disease. Sunday, April 9. Eight hours. Fee: $25.00.

Problems in Neurology and Neurosurgery. Saturday, May 6. Eight hours. Fee: $25.00.

Psychological Problems in General Practice. Sunday, May 21. Eight hours. Fee: $25.00.

Horizons in Surgery. Saturday, June 17. Eight hours. Fee: $25.00.

Note:
Each one of the conferences listed above..... $ 25.00

General Review Course for Practicing Physicians. Thursday through Saturday. March 16 through 18. Fees: Entire Course $35.00; two days $25.00; one day $15.00.

Conference on Strabismus. Wednesday through Friday. July 26 through 28. Limited enrollment. Fee: $100.00.

Contact: Arthur Selzer, M.D., program committee chairman, Presbyterian Medical Center. Clay and Webster Sts., San Francisco 15, WEst 1-8000, Ext. 303.

UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES

Ward Walks in Rare Diseases. Thursday evenings, May 4 to July 6, 7:30-9:30 p.m. Los Angeles County Hospital. Limited enrollment. Tuition: $100.00.

Hawaii Course. August 2 through 18. The USC School of Medicine will offer the 4th Postgraduate Refresher Course to be held in Honolulu and on board the S.S. Matsonia. (As a time and money saver, air travel is also possible.)

Cardiac Resuscitation. Each Wednesday by appointment, 4 to 6 p.m. USC Medical Research Building, Room 211, 2025 Zonal Avenue. Tuition: $30.00. (Each session all-inclusive.)

Basic Home Course in Electrocardiography. One year postgraduate series, electrocardiogram interpretation by mail. Physicians may register at any time and receive all 52 issues. Fifty-two weeks. Fee: $100.00.

*Fee to be announced.
†Hours and fees to be announced.

Advance Home Course in Electrocardiography. One year postgraduate series, electrocardiogram interpretation by mail. Fifty-two issues: $85.00. Physicians may register at any time.

Contact: Phil R. Manning, M.D., Associate Dean and Director, Postgraduate Division, University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 33. CApital 5-1511.

COLLEGE OF MEDICAL EVANGELISTS

SURGICAL ANATOMY (Dissection, Lectures and Demonstrations):

Head and Neck. Monday and Wednesday, April 19 through May 31. Sixty-three hours. Fee: $75.00.

SURGICAL ANATOMY (Lectures and Demonstrations only):

Head and Neck. Wednesdays, April 12 through May 31. Twenty-four hours. Fee: $35.00.

Joint Manipulation. Monday through Friday, March 20 through 24. Twenty hours. Fee: $100.00.

Tropical Public Health. Monday through Friday, April 3 through 28. Fee: $65.00.

Clinical Traineeships available in clinical departments by arrangement with Postgraduate Division and Postgraduate Chairman of department involved. In addition to those listed other traineeships in other departments can be arranged. Eighty hours minimum. Limited enrollment. Begin when individually arranged.

1. **Anesthesia.** Six months. 250 to 300 hours. Fee: $350.00.
2. **Internal Medicine.** Two weeks to nine months.
3. **Pulmonary Diseases** (can be arranged).
4. **Traumatology.** One month. 160 hours. Fee: $125.00.
5. **Urology** (can be arranged).

For information contact: Division of Postgraduate Medicine, College of Medical Evangelists, 1720 Brooklyn Ave., Los Angeles 33. ANgelus 9-7241, Ext. 214.

CALIFORNIA MEDICAL ASSOCIATION ANNUAL SESSION POSTGRADUATE COURSES

Clinical Neurology in cooperation with College of Medical Evangelists. White Memorial Hospital. Sunday, April 30, 9-12 a.m.; Monday and Tuesday, May 1 and 2, 2-5 p.m. Fee: $25.00.*

Office Gynecology in cooperation with USC School of Medicine. Los Angeles County Hospital. Saturday, April 29, 9-12 a.m. and 2-5 p.m.; Sunday, April 30, 9-12 a.m. Fee: $25.00.*

Use and Limitations of Laboratory Tests in cooperation with USC School of Medicine. Los Angeles County Hospital. Saturday, April 29, 9-12 a.m. and 2-5 p.m.; Sunday, April 30, 9-12 a.m. Fee: $25.00.*

Cardiac Resuscitation: in cooperation with USC School of Medicine. USC Research Building, Room 211, 2025 Zonal Avenue, Los Angeles 33. Section I: Saturday, April 29, 9 to 11 a.m.; Section II: Sunday, April 30, 2-4 p.m. (each Section is all-inclusive). Each Section is limited to 15 registrants from areas other than Los Angeles and San Francisco. Fee: $30.00, each Section.*

*Chartered buses for Registrants will leave the Ambassador Hotel at 8:00 a.m. each morning.

CALIFORNIA MEDICAL ASSOCIATION POSTGRADUATE INSTITUTES—1961

North Coast Counties, March 23 and 24, Flamingo Hotel, Santa Rosa, in cooperation with University of California, San Francisco. *Chairman:* Milton A. Antipa, M.D., 50 Montgomery Drive, Santa Rosa.

San Joaquin Valley, April 14 and 15, Ahwahnee Hotel, Yosemite, in cooperation with UCLA School of Medicine. *Chairman:* J. Malcolm Masten, M.D., 1051 R Street, Fresno.

Sacramento Valley Counties, June 30 and July 1, in cooperation with Stanford University School of Medicine, Tahoe Tavern, Lake Tahoe. *Chairman:* Joel T. Janvier, M.D., 3632 Marysville Road, Del Paso Heights.

* * *

AUDIO-DIGEST FOUNDATION

A nonprofit subsidiary of the C.M.A., offers (on a subscription basis) a series of six different hour-long tape recordings covering general practice, surgery, internal medicine, obstetrics and gynecology, pediatrics and anesthesiology. Designed to keep physicians posted on what is new and important in their respective fields, these programs survey current national and international literature of interest and contain selected highlights of on-the-spot recordings of national scientific meetings, panel discussions, symposia, and individual lectures. For information contact Mr. Claron L. Oakley, Editor, 1919 Wilshire Blvd., Los Angeles 57, HUbbard 3-3451.

Medical Dates Bulletin

MARCH MEETINGS

PIONEERS MEMORIAL HOSPITAL 11th Annual Medical and Surgical Postgraduate Assembly. March 17 and 18. Pioneers Memorial Hospital, Brawley. *Contact:* George C. Holleran, M.D., program chairman, P. O. Box 159, Brawley.

ST. JOSEPH'S HOSPITAL Second Annual Medical Assembly. March 24 and 25, St. Joseph's Hospital Auditorium, 501 South Buena Vista St., Burbank. *Contact:* Reuben Straus, M.D., chairman, program committee, St. Joseph's Hospital, 501 S. Buena Vista St., Burbank.

THIRD ANNUAL CANCER SEMINAR presented by the American Cancer Society, Nevada Division, Inc., Reno. To be held at the Riverside Hotel Garden Room, Reno, March 28 to 30. *Contact:* American Cancer Society, Nevada Division, Inc., 101 W. Arroyo Street, Reno, Nevada.

FIFTH ANNUAL POSTGRADUATE SYMPOSIUM ON HEART DISEASE sponsored by San Mateo and Santa Clara County Heart Associations, March 29, Veterans' Administration Hospital, 3801 Junipero Serra Blvd., Palo Alto, 9:00 a.m. to 5:30 p.m. *Contact:* John S. Blum, executive director, San Mateo County Heart Association, 45 North B Street, San Mateo, or Mr. William Allayaud, executive director, Santa Clara Heart Association, 461 Porter Building, San Jose.

APRIL MEETINGS

INDUSTRIAL MEDICAL ASSOCIATION. Biltmore Hotel, Los Angeles, April 11 through 13. *Contact:* Leonard Arling, M.D., secretary, The Northwest Industrial Clinic, 3101 University Avenue, S.E., Minneapolis 14.

FOURTH ANNUAL PALO ALTO CLINIC SYMPOSIUM sponsored by the Clinic and the Palo Alto Medical Research Foundation, April 15, 300 Homer Avenue, Palo Alto. *Contact:* John F. Weigen, M.D., program chairman, Palo Alto Clinic, 300 Homer Avenue, Palo Alto.

CALIFORNIA MEDICAL ASSOCIATION Annual Meeting, Ambassador Hotel, Los Angeles. April 30 through May 3. *Contact:* John Hunton, executive secretary, 693 Sutter Street, San Francisco 2; or Ed Clancy, director of public relations, 2975 Wilshire Blvd., Los Angeles 5.

PACIFIC COAST OTO-OPHTHALMOLOGICAL SOCIETY ANNUAL MEETING. April 30-May 4. Riviera Hotel, Palm Springs. *Contact:* Al Miller, M.D., Secretary, 500 South Lucas Ave., Los Angeles 17.

MAY MEETINGS

LOS ANGELES COUNTY HEART ASSOCIATION Annual Meeting, May 3, 12:00 noon to 2:00 p.m. Pacific Ballroom, Statler Hilton Hotel, Los Angeles. *Contact:* Mrs. Sally Smalley, Public Information Director, 2405 W. 8th Street, Los Angeles 57.

CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICERS Semi-Annual Meeting, May 4 and 5, Los Angeles. *Contact:* Donald G. Davy, M.D., State Department of Public Health, 2151 Berkeley Way, Berkeley 4.

HAWAII MEDICAL ASSOCIATION ANNUAL MEETING. May 4-7. Honolulu, Hawaii. *Contact:* Lee McCaslin, Executive Secretary, 510 So. Beretania, Honolulu 13.

LONG BEACH SURGICAL SOCIETY, Fourth Annual Clinic Day. May 10. The Virginia Country Club, 4602 Virginia Road, Long Beach. *Contact:* Robert T. Fox, M.D., secretary, 3712 Atlantic Avenue, Long Beach 7.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS (for members and invited guests). May 10-12. Del Monte Lodge, Pebble Beach. *Contact:* William J. Engel, M.D., Secretary-Treasurer, Cleveland Clinic, 2020 E. 93rd St., Cleveland 6, Ohio.

NEVADA CHAPTER AMERICAN ACADEMY OF GENERAL PRACTICE. May 18-20, Riverside Hotel, Reno, Nevada. *Contact:* John M. Watson, Secretary, 1845 Prater Way, Sparks, Nevada.

MEDICAL STAFF OF CHILDREN'S HOSPITAL OF THE EAST BAY Ninth Annual Clifford Sweet Seminar. May 18, 19 and 20. Hotel Claremont, Berkeley, and Children's Hospital of the East Bay. *Contact:* Seymour J. Harris, M.D., chairman, Lectureship Committee, 401 29th Street, Oakland 9.

CALIFORNIA HEART ASSOCIATION Annual Meeting and Scientific Session. May 19 through 21, Disneyland Hotel, Anaheim. *Contact:* J. Keith Thwaites, Exec. Director 1370 Mission Street, San Francisco.

AMERICAN ORTHOPAEDIC ASSOCIATION (members and guests). May 22-25. The Ahwahnee Hotel, Yosemite. *Contact:* Lee Ramsay Straub, M.D., Secretary, 535 E. 70th St., New York 21.

AMERICAN UROLOGICAL ASSOCIATION, INC. May 22-25. Biltmore Hotel, Los Angeles. *Contact:* Mr. William P. Didusch, Executive Secretary, 1120 N. Charles St., Baltimore 1.

MEMORIAL HOSPITAL OF LONG BEACH, Third Annual Medical Staff Symposium. May 24. New Memorial Hospital, 2801 Atlantic Ave., Long Beach 6. *Contact:* George X. Trimble, M.D., secretary, Memorial Hospital of Long Beach.

SUMMER AND FALL MEETINGS

WESTERN BRANCH, AMERICAN PUBLIC HEALTH ASSOCIATION Annual Meeting (joint with U. S.-Mexico Border Public Health Association). June 26 through 29. El Cortez Hotel, San Diego. *Contact:* Robert E. Mytinger, M.P.H., director, Executive Office Western Branch, APHA, 693 Sutter Street, San Francisco 2.

NEVADA STATE MEDICAL ASSOCIATION 58th Annual Meeting and 11th Annual Conference of the Reno Surgical Society. August 23-26. Reno, Nevada. *Contact:* Mr. Nelson B. Neff, Exec. Secretary, Nevada State Medical Association, 506 Humboldt St., Reno.

ST. JOHN'S HOSPITAL Postgraduate Assembly. September 14 through 16. St. John's Hospital, 1328 22nd St., Santa Monica. *Contact:* John C. Eagan, M.D., director, 1328 22nd St., Santa Monica.

WASHINGTON STATE MEDICAL ASSOCIATION Annual Convention. September 17-20. Olympic Hotel, Seattle, Wash. *Contact:* R. W. Neill, 1309 7th Ave., Seattle.

CALIFORNIA SOCIETY OF INTERNAL MEDICINE Annual Meeting. September 29 through October 1. Hotel del Coronado, Coronado. *Contact:* Philip L. Pillsbury, M.D., secretary-treasurer, 350 Post Street, San Francisco 8.

WESTERN INDUSTRIAL MEDICAL ASSOCIATION Western Occupational Health Conference, October 6 and 7, Biltmore Hotel, Los Angeles. *Contact:* B. M. Brundage, M.D., Medical Director, Atomics International, P. O. Box 309, Canoga Park, Calif.

LOS ANGELES COUNTY HEART ASSOCIATION Professional Symposium. October 11-12. 9 a.m.—5 p.m., Statler Hilton Hotel, Los Angeles. *Contact:* Manuel Siegel, Program Director, 2405 W. 8th St., Los Angeles 57.

CALIFORNIA ACADEMY OF GENERAL PRACTICE 1961 Scientific Assembly. October 15-18. Statler Hilton Hotel, Los Angeles. *Contact:* William W. Rogers, Exec. Secretary, 461 Market Street, San Francisco 5.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC., October 22 to 27, Statler Hilton, Los Angeles. *Contact:* Mr. John W. Andes, executive secretary, 515 Busse Highway, Park Ridge, Illinois.

AMERICAN COLLEGE OF CHEST PHYSICIANS Seventh Annual Postgraduate Course on Diseases of the Chest, December 4 to 8, 9 to 5 daily, Statler Hilton Hotel, Los Angeles. *Contact:* Mr. Murray Kornfeld, executive director, 112 East Chestnut Street, Chicago 11, Illinois.

THE PHYSICIAN'S *Bookshelf*

FUNDAMENTALS OF CHEST ROENTGENOLOGY—Benjamin Felson, M.D., Professor and Director, Department of Radiology, University of Cincinnati College of Medicine; Director, Departments of Radiology, Cincinnati General, Children's, Daniel Drake, Dunham, Christian R. Holmes, and Longview Hospitals; and Special Consultant, United States Public Health Service. W. B. Saunders Company, Philadelphia, 1960. 301 pages, with 450 illustrations on 238 figures, $10.00.

This book consists of a series of ten chapters dealing with the roentgen examination of the chest and the author's experience with mass survey work during World War II.

The sections on orderly roentgen examination and the localization of intrathoracic lesions are commendable. However, in extolling laminography, it would be useful if the author mentioned some simple means of differentiating bullae from cavities, and normal bronchi from ectatic ones.

The various anatomic entities, lobes, segments, hila, pleura and diaphragm are separately considered. (It is hoped that an international commission will decide on hil*a* versus hil*i* at an early date.)

Figure 163 is labelled "middle lobe syndrome." The author of this misleading term has long since withdrawn it from the literature, so perhaps it would be simpler to use the word "middle lobe bronchial stenosis."

Figure 211 illustrates the overlap shadow of the heart in right lower lobe collapse. It should be added that simple elevation of the right hemidiaphragm (both congenital and acquired) may result in a similar misleading appearance of interlobar fluid.

The wisdom of giving specific names to minor findings reflects an attitude more Bostonian than scientific. For example, on page 252, the "vallecular sign" is described, without mentioning the fact that simple retention of barium water in the valleculae and pyriform sinuses is often a normal momentary phenomenon.

Specific normal variations in an extensive series of apparently negative chest roentgenograms are well described in the final chapter. The illustrations are good and the text clear. Recommended for students.

* * *

YEAR BOOK OF OBSTETRICS AND GYNECOLOGY (1960-1961 Year Book Series)—Edited by J. P. Greenhill, B.S., M.D., F.A.C.S., F.I.C.S. (Honorary) Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Cook County Hospital; and Senior Attending Obstetrician and Gynecologist, Michael Reese Hospital. The Year Book Publishers, Incorporated, 200 East Illinois Street, Chicago 11, Ill., 1960. 576 pages, $8.00.

This publication has appeared each year since 1900, initially as separate volumes for obstetrics and for gynecology, but as a single volume since 1918. The present editor has been associated with the Year Book since 1923, first assisting the late Joseph B. DeLee with the obstetric section, then as editor of the section on gynecology, and finally as editor of the entire volume during the last eighteen years. It seems likely that the interesting history of the various Year Books, and of this one in particular, is not known to large numbers of younger obstetricians and gynecologists who have entered the specialty since the end of World War II, and one would hope that the editor and publishers would consider providing a brief historical sketch in next year's issue. Nothing of this sort has been attempted since the 1940 edition.

It would be of interest also to have some prefatory remarks on the preparation of the volume—what journals are chosen for abstracting and why, what determines acceptance or rejection of an article, why some abstracts are followed by pages of fine print consisting of additional shorter abstracts that quite often have precious little to do with the major item they appear to be elaborating upon. They seem to be orphaned items that can't conveniently be abandoned, so they're tossed in to decorate the editorial comment, but all too often they represent the editorial effort in its entirety. One wonders why these hard-to-read sub-abstracts are always signed "—Ed." while those in larger type are anonymous.

Despite these criticisms the Year Book continues to be a useful compendium of current literature and its obvious popularity over sixty years is well deserved. Most purchasers of previous editions undoubtedly have already been afforded a look at the 1960-61 issue, thanks to the diligent efforts of the publishers, and those who are not acquainted with the book should treat themselves to a view of the vast array of fact and fantasy crammed into these 575 pages.

CHAS. E. MCLENNAN, M.D.

* * *

CARE OF THE WELL BABY—Medical Management of the Child from Birth to 2 Years of Age—Kenneth S. Shepard, M.D., Director of Well Baby Clinics, Northwestern University School of Medicine; Staff Examiner, Infant Welfare Society, Evanston; Pediatrician, Evanston Hospital Association and St. Francis Hospital, Evanston; American Board of Pediatrics. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pennsylvania, 1960. 224 pages, $3.25.

This small paper-back book is a treatise in a very abbreviated form concerning the management of new born infants up to two years of age. Emphasis is given to the psychological and emotional relationship that should exist between the pediatrician and the mother; the father being almost being completely ignored in this book.

The whole is an expression of the technique developed by the author in his experience in dealing with this age group. It cannot be said that all the views expressed are those of pediatricians generally. There are many areas where disagreement might be found.

This book would not change the methods of practice in a well established pediatrician. It would be of some value to a young pediatrician just entering private practice in helping him to establish his own methods and patterns of practice.

APPLICATION FOR HOUSING ACCOMMODATIONS

FOR YOUR CONVENIENCE in making hotel reservations for the coming meeting of the **California Medical Association,** April 30*-May 3, 1961, Los Angeles, hotels and their rates are at the right. Use the form at the bottom of this page, indicating your first and second choice. Because of the limited number of single rooms available, your chance of securing accommodations of your choice will be better if your request calls for rooms to be occupied by two or more persons. **All requests for reservations must give definite date and hour of arrival as well as definite date and approximate hour of departure; also names and addresses of all occupants of hotel rooms must be included.**

Ninetieth Annual Session
CALIFORNIA MEDICAL ASSOCIATION
Los Angeles, California
APRIL 30*-MAY 3, 1961

HOTEL ROOM RATES†

	Single	Twin Beds	Suites
AMBASSADOR HOTEL			
3400 Wilshire Boulevard			
Main Building	14.00-24.00	18.00-28.00	40.00-58.00
Garden Studios	22.00-34.00	24.00-36.00	54.00-66.00
CHAPMAN PARK HOTEL			
3405 Wilshire Boulevard	10.00-11.00	14.00-16.00	20.00-28.00
Bungalows		18.00	25.00-28.00
THE GAYLORD HOTEL			
3355 Wilshire Boulevard	9.00-10.00	12.00-15.00	Single: 25.00 Double: 35.00
HOTEL CHANCELLOR			
3191 West Seventh Street	8.00-10.00	12.00	
SHERATON-WEST (formerly Sheraton-Town House)			
2961 Wilshire Boulevard	12.50-20.00	17.50	34.00

ALL RESERVATIONS MUST BE RECEIVED BEFORE: APRIL 1, 1961

***April 29: House of Delegates will start with afternoon meeting Saturday, April 29.**

†The above quoted rates are existing rates but are subject to any change which may be made in the future.

CALIFORNIA MEDICAL ASSOCIATION—Dept. 74
693 Sutter Street
San Francisco 2, California

Please reserve the following accommodations for the 90th Annual Session of the California Medical Association, in Los Angeles April 30-May 3, 1961. (House of Delegates members: First meeting of House begins Saturday afternoon, April 29.)

Single Room $..... Twin-Bedded Room $.....

Small Suite $..... Large Suite $..... Other Type of Room $.....

First Choice Hotel..... Second Choice Hotel.....

ARRIVING AT HOTEL (date):.....Hour:.....A.M.....P.M. } Hotel reservations will be held until

Leaving (date) .....Hour:.....A.M.....P.M. } 6:00 p.m., unless otherwise notified

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Therefore, please include the names of both persons for each twin-bedded room requested. Names and addresses of all persons for whom you are requesting reservations and who will occupy the rooms asked for:

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.....

.....

Individual Requesting Reservations—Please print or type Officer?..... Delegate?..... Alternate?.....

Name..... County.....

Address..... City and State.....

COMMISSION ON CANCER
CALIFORNIA MEDICAL ASSOCIATION

PRE-CONVENTION CONFERENCES

LOS ANGELES • SATURDAY, APRIL 29

Radiology

Grove Lounge, Ambassador Hotel

Chairman.....D. J. Sayles, M.D., San Diego
Secretary.....John Heald, M.D., San Francisco

THERAPY SESSION—9:30 a.m. to 11:30 a.m.

Cases with specific therapy problems will be presented. The audience is asked to participate actively.

DIAGNOSTIC SESSION—2:00 p.m. to 4:00 p.m.

Diagnostic cases with histories and films will be presented. Cases have been selected to illustrate specific problems in the radiological and clinical diagnosis of cancer. Audience participation and discussion are urgently requested.

Pathology

9:00 a.m. to noon • 2:00 p.m. to 4:30 p.m.

East and West Venetian Rooms, Ambassador Hotel

Moderators: ROBERT MOWRY, M.D., Birmingham, Alabama, by invitation.
PERRY MELNICK, M.D., Los Angeles.

This Pre-Convention Conference on Histochemistry will be conducted under the chairmanship of Frank R. Dutra, M.D., Castro Valley.

Members who wish to attend this conference are requested to register now with Weldon K. Bullock, M.D., Registrar, Tumor Tissue Registry, C.M.A. Cancer Commission, Los Angeles County Hospital, 1200 North State Street, Los Angeles 33.

4:45 p.m.

Semi-annual Meeting of California Society of Pathologists—Henry Moon, M.D., San Francisco, presiding.

7:00 p.m.

Dinner meeting of the California Society of Pathologists.

CALIFORNIA MEDICAL ASSOCIATION

90th Annual Session

Scientific Sessions

•

Postgraduate Courses

•

Meetings of the House of Delegates

•

Annual Reports

Ambassador Hotel

LOS ANGELES

April 30 to May 3, 1961

PAUL D. FOSTER
President

WARREN L. BOSTICK
President-Elect

Scientific Program

CALIFORNIA MEDICAL ASSOCIATION

Ninetieth Annual Session

Ambassador Hotel

LOS ANGELES

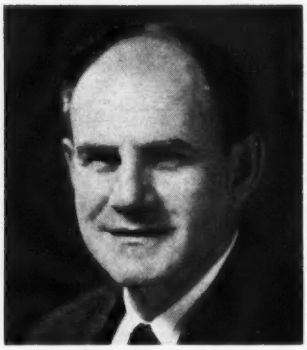
APRIL 30 to MAY 3*

1961

***House of Delegates Opening Meeting**
April 29
3:00 p.m.

INDEX

Guest Speakers



EARL P. BENDITT

IRWIN NYDICK

HENRY TUMEN

RUPERT B. TURNBULL, JR.

RALPH VEENEMA

Guest Speakers

EARL P. BENDITT, M.D., Seattle—Professor and Chairman of the Department of Pathology, University of Washington School of Medicine.

IRWIN NYDICK, M.D., New York City—Assistant Clinical Professor of Medicine, Cornell University Medical College, Research Associate, Sloan-Kettering Institute.

HENRY J. TUMEN, M.D., Philadelphia—Professor and Chairman of the Department of Medicine, University of Pennsylvania Graduate School of Medicine.

RUPERT B. TURNBULL, JR., M.D., Cleveland—Department of Surgery, Cleveland Clinic and Cleveland Clinic Foundation.

RALPH VEENEMA, M.D., New York City—Assistant Professor of Clinical Urology, Columbia University College of Physicians and Surgeons, Chief of Urology Section, Francis Delafield Cancer Research Institute, Columbia Presbyterian Medical Center.

SPECIAL GUESTS OF SECTIONS

WALTER CLOWERS, M.D., Washington, D.C.—Chief of Program Services Branch, Division of Health Mobilization, U. S. Public Health Service.

VIRGIL S. COUNSELLER, M.D., Phoenix—Emeritus Professor of Surgery, University of Minnesota, Mayo Foundation; Emeritus Surgeon, Mayo Clinic.

ARNOLD P. FRIEDMAN, M.D., New York City—Associate Professor of Clinical Neurology, Columbia University College of Physicians and Surgeons, Physician in Charge, Headache Unit, Montefiore Hospital.

FRANK PERLMAN, M.D., Portland, Oregon—Assistant Clinical Professor of Medicine, University of Oregon Medical School.

CHARLES L. SCHNEIDER, M.D., Ann Arbor, Michigan—Professor of Obstetrics and Physiology, University of Michigan Medical School.

INDEX TO SPEAKERS*

*This list does not include participants on the motion picture program on pages 32 and 33.

Information

BADGES. It is important that badges be worn at all times. Admission to scientific meetings is by badge only.

COUNCIL. Frenchette Room. The first meeting of the Council will be held Saturday, April 29 at 9:30 a.m. Further meetings will be held each morning at 7:30 a.m.

DELEGATES. For list of delegates, meeting times, places and agenda, see pages 48 to 53.

EMERGENCY CALLS AND MESSAGES: Convention Emergency Call Number: DUnkirk 1-2191—8:30 a.m. to 5:00 p.m.

MESSAGE CENTER (DUnkirk 1-2191) — *Provided through the courtesy of the Pacific Telephone and Telegraph Company*—Registration Desk, Ballroom, Casino Floor—Open 8:30 a.m. to 5:00 p.m.—The Association will *attempt* to transmit messages to the individual physician. Each physician should notify his own office of the exact times and meetings he plans to attend, and the convention number.

In case of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, HUbbard 3-1581.

POSTGRADUATE COURSES. For program, meeting times and places, see pages 34 to 36.

EXHIBITS. Technical Exhibits — Ballroom, Sunset Room and Boulevard Room, Casino Floor. See pages 38 to 46.

Scientific Exhibits—Venetian Room Foyer, South End of Lobby. See list on page 31.

Medical Motion Pictures will be shown in the West Venetian Room. See program synopsis, pages 32 to 33.

You are urged to visit and attend all exhibits.

MEETING TIMES AND PLACES. See chart on page 9 for exact times and places of general and section meetings.

REGISTRATION. Registration and information desks are located in the Ballroom Foyer, Casino Floor. *All members, guests, and visitors are requested to register immediately on arrival.* There is no charge for registration, except for Postgraduate Courses. Registration desks are open Saturday through Wednesday. *Admission to the general and section sessions and exhibits areas is by badge only.*

QUALIFICATIONS/REQUIREMENTS FOR REGISTRATION. (a) All M.D.'s with credentials showing that they hold valid license to practice medicine. (Membership card in C.M.A.; county medical society/association or A.M.A. membership card.) (b) Medical students will be admitted upon presentation of credentials from their medical schools identifying them as medical students. (A membership card of the Student American Medical Association or letter from their dean's office.) (c) Medical secretaries will be admitted upon presentation of a letter from the physician-employer. (d) Pharmacist mates and other military personnel of a like grade will be admitted upon presentation of a letter requesting their admittance, written by their commanding officer. (e) Dentists (D.D.S.), doctors of veterinary medicine (D.V.M.), registered nurses (R.N.), student nurses, x-ray technicians, laboratory technicians, dietitians, allied public health personnel, and others will be admitted provided they have proper identification. (f) *All questions on admission will be passed upon by a member of the Committee on Registration who will be present at the desk.*

Other Meetings and Entertainment

• SATURDAY, APRIL 29

C.M.A. HOUSE OF DELEGATES OPENING SESSION—Embassy Room, 3:00 p.m.

C.M.A. Cancer Commission Conferences on Radiology and Pathology—Venetian Rooms, Pathology; Grove Lounge, Radiology; 9:00 a.m. to 4:30 p.m.

California Society of Pathology—Venetian Rooms, Semi-annual Meeting, 4:45 p.m.

• SUNDAY, APRIL 30

PRESIDENTS' RECEPTION AND DINNER DANCE—Reception, 7 p.m., Embassy Room; Dinner Dance, Cocoanut Grove, Ambassador Hotel, 8:00 p.m. Formal dress optional. Honoring the Presidents of the California Medical Association and the Woman's Auxiliary. Tickets on sale in the Main Floor Lobby.

C.M.A. Section on Allergy and California Society of Allergy Luncheon—Oval Room A, 12:30 p.m.

C.M.A. Section on Allergy and California Society of Allergy Reception and Dinner—Reception at 7:00 p.m., Embassy Room; Dinner Dance at 8:00, Cocoanut Grove (Joining C.M.A. Presidents' Reception and Dinner Dance).

C.M.A. Section on Orthopedics Luncheon—Colonial Room, 12:30 p.m.

• MONDAY, MAY 1

A.M.A. Delegates Meeting—Lido Room, 2:30 p.m.

Past Presidents' Luncheon—Oval Room A, noon.

Bureau of Medical Economics Meeting—Oval Room C, 9:00 a.m. to 4 p.m.

C.M.A. ANNUAL MEETING—1961 — SCIENTIFIC SESSIONS

LOCATION	SUNDAY APRIL 30		MONDAY MAY 1		TUESDAY MAY 2		WEDNESDAY MAY 3	
AMBASSADOR HOTEL (Lobby Floor)	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
Embassy Room	**9:30 a.m.†** **House of Delegates** †See note below for Opening Session	**2 p.m.** General Meeting Inflammatory Diseases of the Colon	**9 a.m.** General Meeting Diagnostic Methods of Gastroenterology		**9 a.m.** General Meeting Five Guests Five Topics	**4:00 p.m.** **House of Delegates**	**9:30 a.m.** **House of Delegates**	
West Venetian Room	**9 a.m.** Internal Medicine	**2 p.m. & 8 p.m.** Film Symposium	**9 a.m.** Film Symposium	**2 p.m. & 8 p.m.** Film Symposia	**9 a.m.** Film Symposium	**2 p.m. & 8 p.m.** Film Symposia	**9 a.m.** Film Symposium	**2 p.m.** Film Symposium
East Venetian Room	**9 a.m.** Pathology					**2 p.m.** Industrial Medicine Physical Medicine General Practice		**2 p.m.** Public Health
Regency Room	**9 a.m.** Obstetrics and Gynecology	**2 p.m.** Eye Anesthesiology		**2 p.m.** Anesthesiology		**2 p.m.** Obstetrics and Gynecology Anesthesiology	**9 a.m.** Neurology	**2 p.m.** Psychiatry
Grove Lounge	**9 a.m.** Dermatology	**2 p.m.** Ear, Nose, Throat					**9 a.m.** Urology	**2 p.m.** Urology
Lido Room	**9 a.m.** Radiology	**2 p.m.** Radiology			**9 a.m.** Physical Medicine			**2 p.m.** Internal Medicine
Colonial Room	**9 a.m.** General Surgery					**2 p.m.** Disaster Medical Care		
Rose Room	**9 a.m.** Orthopedics							
(Casino Floor) Oval Room A	**9 a.m.** Allergy	**12:30 p.m.** Allergy Luncheon and Business Meeting						**2 p.m.** Pediatrics
WHITE MEMORIAL HOSPITAL	**9 a.m.*** **(Bus at 8 a.m.*)** Postgraduate Course C.M.E.			**2 p.m.** Postgraduate Course C.M.E.		**2 p.m.** Postgraduate Course C.M.E.		
L. A. COUNTY HOSPITAL USC SCHOOL OF MEDICINE (Starts Saturday)	**9 a.m.*** **(Bus at 8 a.m.*)** Postgraduate Course U.S.C.	**2 p.m.** P.G. Course—Cardiac Resuscitation—U.S.C.						

*Buses will leave Ambassador Hotel, Wilshire Entrance.
U.S.C. Courses will start on Saturday.
†Opening meeting, House of Delegates, 3:00 p.m., Saturday, April 29.

TECHNICAL EXHIBITS—Sunset Room, Ballroom and Boulevard Room, Casino Floor.
SCIENTIFIC EXHIBITS—Venetian Room Foyer.
COUNCIL OF THE C.M.A. MEETS DAILY AT 7:30 A.M. IN THE FRENCHETTE ROOM.

SCIENTIFIC SESSIONS

GENERAL MEETINGS

FIRST GENERAL MEETING

SUNDAY, APRIL 30

2:00—Embassy Room, Lobby Floor

Symposium

Inflammatory Diseases of the Large Bowel

Moderator: Philip R. Westdahl, M.D., San Francisco
Chairman of Section on General Surgery

Panelists: Sherman Mellinkoff, M.D., Professor of Medicine, University of California at Los Angeles.

Walter L. Stilson, M.D., Professor of Radiology, College of Medical Evangelists, Los Angeles.

Henry J. Tumen, M.D., Professor and Chairman of the Department of Medicine, University of Pennsylvania Graduate School of Medicine, Philadelphia.

Rupert B. Turnbull, Jr., M.D., Staff, General Surgery, Cleveland Clinic and Cleveland Clinic Foundation.

Each speaker will talk primarily on Chronic Ulcerative Colitis as related to his field, to be followed by a question and answer period. Members of the audience are strongly urged to submit questions to the panel.

SECOND GENERAL MEETING

MONDAY, MAY 1

9:00—Embassy Room, Lobby Floor

Symposium

Newer Diagnostic Methods in Gastroenterology

Moderator: Charles D. Armstrong, M.D., Menlo Park
Chairman, Section on Internal Medicine

Panelists: Earl P. Benditt, M.D., Professor and Chairman of the Department of Pathology, University of Washington School of Medicine, Seattle.

John V. Carbone, M.D., Associate Professor of Medicine, University of California School of Medicine, San Francisco.

Bernard J. Haverback, M.D., Assistant Professor of Medicine and Head of Gastrointestinal Section, University of Southern California School of Medicine, Los Angeles.

Irwin Nydick, M.D., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York City.

Henry J. Tumen, M.D., Professor and Chairman of the Department of Medicine, University of Pennsylvania Graduate School of Medicine, Philadelphia.

Members of the audience are requested to submit questions to the panel.

12:00—Embassy Room Foyer, Lobby Floor

Luncheon Meeting

Question and Answer Period on Diagnostic Methods in Gastroenterology

Luncheon Tickets must be purchased in advance.

See page 11 for ticket information.

THIRD GENERAL MEETING

TUESDAY, MAY 2

9:00—Embassy Room, Lobby Floor

Moderator: Charles D. Armstrong, M.D., Menlo Park

9:00—**Fine Structure and Histochemistry of Some Renal and Vascular Lesions**—Earl P. Benditt, M.D., Seattle, by invitation.

9:30—**Thrombolytic Therapy of Coronary Thrombosis and Myocardial Infarction**—Irwin Nydick, M.D., New York City, by invitation.

10:00—**Diagnostic Approach to Ulcerating Gastric Lesions**—Henry J. Tumen, M.D., Philadelphia, by invitation.

10:30—**Parathyroid Tumors—Intermittent Function, A Pitfall in Diagnosis**—Ralph J. Veenema, M.D., New York City, by invitation.

11:00—**Pharmacological Approach to the Treatment of Headache**—Arnold P. Friedman, M.D., New York City, by invitation.

11:30—**Postoperative Staphylococcal Diarrhea**—Rupert B. Turnbull, M.D., Cleveland, by invitation.

SPECIAL MEETING

TUESDAY, MAY 2

2:00—Colonial Room, Lobby Floor

Symposium

Disaster Medical Care

General Chairman: Justin J. Stein, M.D., Los Angeles
Presiding: Charles C. Henderson, M.D., San Mateo

2:00—**Address of Welcome**—Paul D. Foster, M.D., President, California Medical Association, Los Angeles.

2:10—**The State Medical Association and Disaster Medical Care**—Charles C. Henderson, M.D., Member, C.M.A. Disaster Medical Care Committee, San Mateo.

2:25—**The National Disaster Medical Care Program of the U. S. Public Health Service**—Walter Clowers, M.D., by invitation, Chief of Program Services Branch, Division of Health Mobilization, USPHS, Washington, D. C.

2:55—**The Council on National Security of the American Medical Association: Its Role in Disaster Medical Care**—Frank F. Schade, M.D., Member, Council on National Security, A.M.A., Los Angeles.

3:15—**Present and Future Plans for Disaster Care in California**—Allan K. Jonas, by invitation, Director, State of California Disaster Office, Sacramento.

3:35—**The Medical Disaster Care Program of the California Disaster Office**—Cecil H. Coggins, M.D., by invitation, Chief, Medical and Health Division, State of California Disaster Office, Sacramento.

3:55—**Intermission.**

4:05—**The Use of Armed Forces Reserve Personnel in Civilian Disaster Medical Care**—Lt. Col. Willard James, MSC, USA, by invitation, Deputy Chief of Operations, Medical Section, 6th Army, San Francisco.

4:25—**The Basic Hospital Disaster Plan**—Wayne P. Chesbro, M.D., Member, C.M.A. Disaster Medical Care Committee, Berkeley.

4:45— **Panel Discussion**

The Value of Test Exercises in Disaster Preparation

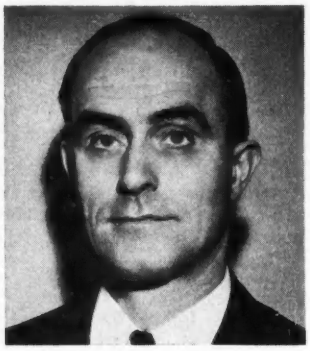
Moderator: Wayne P. Chesbro, M.D., Berkeley

Members of the Panel: Robert Range, M.D., Sacramento; Frank F. Schade, M.D., Los Angeles; Donald E. Barker, M.D., Van Nuys; John S. Chain, M.D., Eureka; William J. Kennedy, M.D., Oakland.

INTERNAL MEDICINE

Chairman.....Charles D. Armstrong, M.D., Menlo Park
Secretary.....Clifford B. Cherry, M.D., Los Angeles
Assistant Secretary.....Glenn A. Pope, M.D., Sacramento

CHARLES D. ARMSTRONG
Chairman



CLIFFORD B. CHERRY
Secretary

SUNDAY, APRIL 30

9:00—West Venetian Room, Lobby Floor

9:00—Urine Glutamic Oxalacetic Transaminase Activity in Acute Myocardial Infarction—Robert B. Kalmansohn, M.D., and Richard W. Kalmansohn, M.D., Los Angeles.

The value of urine glutamic oxalacetic transaminase (UGOT) activity in evaluation of patients with myocardial necrosis is outlined.

9:10—The Sjogren-Mikulicz Syndrome: Its Relationship to Connective Tissue Disorders—Martin A. Shearn, M.D., Oakland.

The previously poorly understood Sjögren and Mikulicz syndromes, now considered a single combined syndrome, is described, and the likelihood of relationship of the syndrome to others of the collagen group is mentioned.

9:20—What Is An Adequate Periodic Examination?—John C. Sharpe, M.D., Beverly Hills.

The experience with complete periodic medical examinations in 500 executives including extensive laboratory, x-ray, and consultative procedures is discussed.

9:30—Oral Hypoglycemic Agents and the Treatment of Diabetes Mellitus—William W. H. Pote, Jr., M.D.; Elmer A. Anderson, M.D.; George Barat, M.D., by invitation; and Arthur J. Riesenfeld, M.D., Los Angeles.

The use of tolbutamide, chlorpromide, and DBI in the treatment of diabetes mellitus is outlined, with emphasis on the fact that their use makes more vital the acceptance of the total treatment of diabetes mellitus.

9:40—The Prevention and Treatment of Postoperative Esophageal Complications—J. Alfred Rider, M.D., Ph.D., San Francisco.

The prevention of esophagitis and esophageal strictures by selection of proper surgical procedures and the importance of early recognition of symptoms of esophagitis are demonstrated.

9:50—Chairman's Address: Cytological Studies in the Diagnosis of Gastric Cancer—Charles D. Armstrong, M.D., Menlo Park.

Description of a simple technique to supplement other methods in the diagnosis of gastric cancer is presented.

10:00—Malabsorption Syndromes—Henry J. Tumen, M.D., Philadelphia, by invitation.

Dr. Tumen succeeded Dr. Henry L. Bockus at the University of Pennsylvania Graduate School of Medicine and is well known for his work in a wide range of gastroenterological subjects.

10:30—An Obscure Hemorrhagic Tendency in Patients with Severe Iron Deficiency Anemia and the Antihemorrhagic Effect of the Repletion of Iron Stores—Arthur J. Samuels, M.D., Beverly Hills.

An obscure hemorrhagic tendency observed in patients with severe iron deficiency and in which the repletion of iron stores halts the hemorrhagic tendency is described.

10:40—Business Meeting.

10:45—Intermission—Joint Section on Pathology in East Venetian Room.

11:00—Serum Enzymes in Disease—Earl P. Benditt, M.D., Seattle, by invitation.

Dr. Benditt, who came to the University of Washington from the University of Chicago, has done extensive work in studies of gastric cytology, serum enzymes, and mast cells.

11:25—Discussion.

11:30—Serum Enzyme Patterns as Aids in the Diagnosis of Disease—Irwin Nydick, M.D., New York City, by invitation.

Dr. Nydick has worked actively at Sloan Kettering Institute in the field of Therapeutic and Diagnostic uses of enzymes.

12:00—**Steroid and Gonadotropic Hormone Patterns in Certain Clinical Disorders**—Gerson Biskind, M.D., San Francisco.

Dr. Biskind is Chief of Pathology at Mt. Zion Hospital and Associate Clinical Professor of Pathology at the University of California School of Medicine.

12:25—Discussion.

12:30—**Automation in the Clinical Laboratory—Demonstration of Techniques by Films**—Thomas V. Feichtmeir, M.D. and Daniel M. Baer, M.D., San Francisco.

Dr. Feichtmeir is Chief of Clinical Pathology and Dr. Baer is a Resident in Pathology at the Veterans Administration Hospital, Ft. Miley, San Francisco.

12:55—Discussion.

SUNDAY, APRIL 30

2:00—Embassy Room, Lobby Floor

First General Meeting

Symposium

Inflammatory Diseases of the Large Bowel

For Program, see General Meetings.

MONDAY, MAY 1

9:00—Embassy Room, Lobby Floor

Second General Meeting

Symposium

Newer Diagnostic Methods in Gastroenterology

For Program, see General Meetings.

TUESDAY, MAY 2

9:00—Embassy Room, Lobby Floor

Third General Meeting

Six guest speakers from out of the state will address the association on subjects of their own specialties.

For Program, see General Meetings.

WEDNESDAY, MAY 3

2:00—Lido Room, Lobby Floor

2:00—**Arteriosclerotic Popliteal Aneurysms—Diagnosis and Management**—S. M. Greenstone, M.D., T. B. Massell, M.D., and E. Craig Heringman, M.D., Los Angeles.

The clinical features of arteriosclerotic popliteal aneurysms are elucidated with emphasis on the availability of successful therapy in order to prevent disastrous complications.

2:10—**The Aggressive Management of Spontaneous Pneumothorax**—Sydney P. Hecker, M.D., and Robert W. Jamplis, M.D., Palo Alto.

Aggressive treatment, to include prompt active measures to quickly re-expand the lung, is shown to shorten the duration of the disability and to minimize complications of spontaneous pneumothorax.

2:20—**The Effect of the Cardiac Arrhythmias on the Circulation of the Vital Organs**—David W. Irving, M.D., Los Angeles, by invitation, Eliot Corday, M.D., Beverly Hills.

The deleterious effects of cardiac arrhythmias on the circulation of the kidney, brain, and gastrointestinal tract have been demonstrated by new techniques.

2:30—**Pseudo-Raynaud's: Cryoglobulinemia Secondary to Occult Neoplasm**—Casimir A. Domz, M.D., and Charles G. Chapman, M.D., Santa Barbara.

Cryoglobulinemia, usually secondary to malignancy, frequently leading to a misdiagnosis of Raynaud's phenomenon can be diagnosed by the simple laboratory determination of cryoglobulin in the serum.

2:40—**Treatment of Advanced Neoplastic Disease with 5-Fluorouracil and Irradiation**—Byron E. Hall, M.D., Ph.D., and James W. Good, M.D., San Francisco.

The value of the pyrimidine antagonist, 5-fluorouracil, in the production of objective improvement in patients with far-advanced cancer is outlined.

3:10—**A Consideration of the Fourth Heart Sound in Clinical Medicine**—John C. Carson, M.D., A. Benchimol, M.D., and E. Grey Dimond, M.D., La Jolla, all by invitation.

The importance of the fourth heart sound, frequently overlooked by the internist, is stressed.

3:20—**Intermission.**

3:30—**Immunological Abnormalities in Lupus Erythematosus**—Halsted R. Holman, M.D., Palo Alto, by invitation.

Dr. Holman was recently named Berthold and Belle N. Guggenhime Professor and Executive of the Department of Medicine, Stanford University, and came to Stanford from the Rockefeller Institute for Medical Research.

4:00—**Differential Diagnosis of Oliguria**—Richards Parker Lyon, M.D., Berkeley.

Criteria for diagnosis in terms of simple bedside methods in differentiation of primary renal disease and renal insufficiency secondary to serious systemic fluid-ion imbalance are outlined.

4:10—**Chromosomal Sex Abnormalities**—Charles P. Miles, M.D., Palo Alto, by invitation.

The paper poses questions in regard to present concepts concerning sex determinants.

4:20—**Aortic Stenosis: Results of So-called Conservative Management**—John Hines Kennedy, M.D., San Diego, by invitation.

The high mortality anticipated in the nonoperative management of aortic stenosis is reaffirmed.

4:30—**Recent Advances in the Treatment of Ulcerative Colitis**—Z. T. Bercovitz, M.D., La Jolla, by invitation.

Recognition of ulcerative colitis as a primary disease above the age of 50 and the use of adrenocorticotropic hormones and adrenocorticosteroids are stressed.

GENERAL SURGERY

Chairman.....Philip R. Westdahl, M.D., San Francisco
Secretary.....William P. Mikkelsen, M.D., Los Angeles
Assistant Secretary.....R. Bruce Henley, M.D., Oakland

PHILIP R. WESTDAHL
Chairman

WILLIAM P. MIKKELSEN
Secretary

SUNDAY, APRIL 30

9:00—Colonial Room, Lobby Floor

9:00— **Seminar**

Recent Advances in the Management of Hypovolemic Shock

9:00—**The Dilemma of Vasopressor and Vasodilator Therapy in the Treatment of Hypotension (Shock)** — Max Harry Weil, M.D., Ph.D., and Herbert S. Shubin, M.D., Los Angeles.

9:20—**Oliguria in the Surgical Patient—Differential Diagnosis and Management**—Leonard Rosoff, M.D., Los Angeles.

9:40—**The Management of Refractory Hypotension in Surgical Patients**—Louis L. Smith, M.D., Los Angeles.

10:00—**Intestinal Stomas**—Rupert B. Turnbull, Jr., M.D., Cleveland, by invitation.

10:30—**Evaluation of Colon Dysfunction**—Donald M. Gallagher, M.D., San Francisco.

Discussion—Rupert B. Turnbull, Jr., M.D., Cleveland.

10:55—**Transitional Cell Carcinoma of the Rectum and Anus**—Lewis Grodsky, M.D., San Francisco.

Discussion—Rupert B. Turnbull, Jr., M.D., Cleveland.

11:15—**Aspiration of Breast Cysts**—Max R. Gaspar, M.D., Long Beach.

11:30—**The Division of Cord Structures in the Management of Inguinal Hernias**—John H. Gifford, M.D., and Robert J. Moes, M.D., Los Angeles.

11:45—**Business Meeting.**

SUNDAY, APRIL 30

2:00—Embassy Room, Lobby Floor

First General Meeting

Symposium

Inflammatory Diseases of the Large Bowel

MONDAY, MAY 1

9:00—Embassy Room, Lobby Floor

Second General Meeting

Symposium

Newer Diagnostic Methods of Gastroenterology

TUESDAY, MAY 2

9:00—Embassy Room, Lobby Floor

Third General Meeting

Six guest speakers from out of the state will address the association on subjects of their own specialties.

For programs, see General Meetings.

GENERAL PRACTICE

Chairman.....Floyd K. Anderson, M.D., Los Angeles
Secretary.....A. J. Franzi, M.D., San Francisco
Assistant Secretary....A. Norton Donaldson, Jr., M.D., Santa Ana

FLOYD K. ANDERSON
Chairman

A. J. FRANZI
Secretary

The Section on General Practice will not conduct a scientific program in order not to conflict with the Postgraduate Courses, the General Meetings, and the Joint Meeting of the Sections on Industrial Medicine and Surgery, General Practice, and Physical Medicine, which this section helped to arrange.

SUNDAY, APRIL 30

2:00—Embassy Room, Lobby Floor

First General Meeting

Symposium

Inflammatory Diseases of the Large Bowel

For Program, see page 10.

MONDAY, MAY 1

9:00—Embassy Room, Lobby Floor

Second General Meeting

Symposium

Newer Diagnostic Methods in Gastroenterology

For Program, see page 10.

TUESDAY, MAY 2

9:00—Embassy Room, Lobby Floor

Third General Meeting

Six guest speakers from out of the state will address the association on subjects of their own specialties.

For Program, see page 10.

TUESDAY, MAY 2

2:00—East Venetian Room, Lobby Floor

Joint Meeting with the Sections on Industrial Medicine and Surgery, and Physical Medicine

Symposium

Traumatic Injuries of the Hand from Various Viewpoints

For Program, See Section on Industrial Medicine and Surgery.

2:00—**From the Viewpoint of Soft Tissue Injury**—Carl Nemethi, M.D., Los Angeles.
Discussion.

2:25—**From the Viewpoint of Orthopedics**—Lewis Cozen, M.D., Los Angeles.
Discussion.

2:50—**From the Viewpoint of Reconstructive Surgery of the Hand**—Herbert H. Stark, M.D., Los Angeles, by invitation.
Discussion.

3:15—**From the Viewpoint of Physical Medicine**—S. Malvern Dorinson, M.D., San Francisco.
Discussion.

3:40—**From the Insurance Company Viewpoint**—Mr. John A. Montgomery, Los Angeles, by invitation.
Discussion.

4:05—**From the Viewpoint of the Industrial Accident Commission**—Mr. Jerry Crowley, Los Angeles, by invitation.
Discussion.

4:30—Rear Portion of East Venetian Room

4:30—**Business Meeting and Election of Officers, Section on General Practice.**

ALLERGY

Chairman.....Hyman Miller, M.D., Beverly Hills
Secretary.....Gardner S. Stout, M.D., San Mateo
Assistant Secretary.....Jerome J. Sievers, M.D., Sherman Oaks

HYMAN MILLER
Chairman

GARDNER S. STOUT
Secretary

SUNDAY, APRIL 30

9:00—Oval Room A, Casino Floor

9:00—**Effect of Hyposensitization on the Development of Allergic Children**—Joseph Rebhun, M.D., Los Angeles.
Discussion.

9:20—**Actifed® in the Treatment of Chronic Conduction Deafness Associated with Perennial Allergic Rhinitis**—Ernest M. Heimlich, M.D., Los Angeles.
Discussion.

9:40—**Vernal Conjunctivitis as an Atopic Disease**—Mathea June Allansmith, M.D., Palo Alto.
Discussion.

10:00—**Allergy to Insect Bites and Stings**—Frank Perlman, M.D., Portland, Oregon, by invitation.
Discussion.

10:20—**Recess.**

10:30—**Patterns of Mortality and Morbidity from Bronchial Asthma in the United States, 1951-1959**—Piero Mustacchi, M.D., San Francisco.
Discussion.

10:50—**Histamine Metabolism**—Gildon N. Beall, M.D., Los Angeles, by invitation.
Discussion.

11:10—**Experiences with Repository-Type Antigens**—John E. Newland, M.D., and A. Zahawi, M.D., Santa Ana.

11:25—**"Single-Injection" Treatment of Allergy, Transfer of Patients from the Multiple Injection Aqueous Type of Extract to the Emulsified Repository Form of Treatment**—Ben C. Eisenberg, M.D., Huntington Park, and Walter R. MacLaren, M.D., Pasadena.
Discussion.

12:00—**Recess.**

12:30—Oval Room A, Casino Floor

12:30—**Luncheon and Business Meeting**—Sponsored jointly by the Section on Allergy and the California Society of Allergy.

7:00—Embassy Room, Lobby Floor

7:00—**Reception before Presidents' Dinner Dance at 8 p.m. in Cocoanut Grove**—The Section on Allergy and the California Society of Allergy will have specially reserved tables. For reservations write Gardner S. Stout, M.D., 39 N. San Mateo Drive, San Mateo. (Tickets $15.00 per person.)

MONDAY, MAY 1

8:00 p.m.—West Venetian Room, Lobby Floor

Medical Motion Picture—Symposium on Allergy

VISIT SCIENTIFIC AND TECHNICAL EXHIBITS

ANESTHESIOLOGY

Chairman.....Roger W. Ridley, M.D., Riverside
Secretary.....Gilbert E. Kinyon, M.D., La Jolla
Assistant Secretary.....Grant Fletcher, M.D., Monterey

ROGER W. RIDLEY
Chairman

GILBERT E. KINYON
Secretary

SUNDAY, APRIL 30

2:00—Regency Room, Lobby Floor

Joint Meeting with Section on Eye

For program, see Section on Eye.

MONDAY, MAY 1

2:00—Regency Room, Lobby Floor

2:00—**Closed System Administration of Fluothane**—Grant Fletcher, M.D., Monterey.
Discussion.

2:30—**An Evaluation of the Cheng Needle in Administration of 1,000 Epidural Anesthetics**—Lt. John M. Sheehan, MC, USN, San Diego, by invitation.
Discussion.

3:00—**Postcardiac By-Pass Hypoxia and Acidosis**—Donald A. Walker, M.D., San Francisco.
Discussion.

3:30—**Postoperative Parotitis**—George E. Lewis, M.D. and Paul H. Lorhan, M.D., Torrance.
Discussion.

4:00—**Effects of Anesthetics on Ventilation and PCO_2 During Patient Initiated Assisted Ventilation** (Winner of the California Society of Anesthesiologists' Resident's Award) — Charles P. Larson, Jr., M.D. and E. I. Eger, M.D., by invitation; and J. W. Severinghaus, M.D., San Francisco.

4:30—**Presentation of Resident's Award by California Society of Anesthesiologists. Section Meeting and Election of Officers.**

TUESDAY, MAY 2

2:00—Regency Room, Lobby Floor

Joint Meeting with the Section on Obstetrics and Gynecology

2:00— **Panel Discussion**

Anesthesia for Obstetrics

Moderator: Charles D. Anderson, M.D., Oakland

Members of the Panel:

Earnest F. Gianotti, M.D., San Francisco, Anesthesiologist.

Raymond E. Ponath, M.D., San Diego, Anesthesiologist.

William S. Kroger, M.D., Beverly Hills, Consulting Editor on Hypnosis and Psychosomatic Medicine, *Western Journal of Surgery, Obstetrics and Gynecology.*

Charles E. Weber, M.D., La Jolla, Obstetrician.

4:30—**Medical Motion Picture: Resuscitation of the Newborn.**

BRING PROPER IDENTIFICATION FOR REGISTRATION

DERMATOLOGY AND SYPHILOLOGY

Chairman.....Eugene M. Farber, M.D., Palo Alto
Secretary.....Paul M. Crossland, M.D., Santa Rosa
Assistant Secretary.....Murray Zimmerman, M.D., Whittier

EUGENE M. FARBER
Chairman

PAUL M. CROSSLAND
Secretary

SUNDAY, APRIL 30

9:00—Grove Lounge, Lobby Floor

9:00—**A New Corticoid for Topical Therapy**—Jud R. Scholtz, M.D., Pasadena.

Discussion: Five minutes.

9:25—**Is Face-Peeling for Wrinkles a Safe and Effective Procedure?**—Samuel Ayres, III, M.D., Los Angeles.

Discussion: Five minutes.

9:50—**The Use of Trimethylpsoralen in Sensitivity Eruptions**—Otto C. Stegmaier, M.D., San Jose, by invitation.

Discussion: Five minutes.

10:15—**Chairman's Address: Variations in the Natural History of Psoriasis**—Eugene M. Farber, M.D., Palo Alto.

10:35—**Recess.**

10:45— **Panel Discussion**

The Diagnosis and Management of Skin Tumors

Moderator: Paul M. Crossland, M.D., Santa Rosa

Members of the Panel: R. R. Allington, M.D., Oakland; Franz Buschke, M.D., San Francisco; Alvin J. Cox, M.D., Palo Alto; Leonard Dobson, M.D., San Francisco; A. Fletcher Hall, M.D., Santa Monica; and Louis H. Winer, M.D., Beverly Hills.

Panel members represent the specialties of pathology, radiology, surgery, chemosurgery, and dermatology. Clinical photos of cases previously unknown to the panel will be shown and a short history of each will be given. Photomicrographs of the histologic features of each tumor will be discussed by the pathologist. Then, various panel members will be asked what form of treatment they would recommend. Finally, the treatment actually given each case will be described, and clinical follow-up pictures will be shown. The audience will be welcome to participate along with panel members.

11:50—**Business Meeting and Election of Officers.**

REGISTRATION

Registration and information desks are located in the Ballroom Foyer, Casino Floor. *All members, guests, and visitors are requested to register immediately on arrival.* There is no charge for registration except for Postgraduate Courses. Registration desks are open Saturday through Wednesday. *Admission to the general and section sessions and exhibit areas is by badge only.*

EAR, NOSE AND THROAT

Chairman.....Heinrich W. Kohlmoos, M.D., Oakland
Secretary.....Marvin W. Simmons, M.D., Fresno
Assistant Secretary.....Henry L. Harris, M.D., Los Angeles

HEINRICH W. KOHLMOOS
Chairman

MARVIN W. SIMMONS
Secretary

SUNDAY, APRIL 30

2:00—Grove Lounge, Lobby Floor

2:00—**Ossifying Fibroma of the Maxillary Sinus**—John Ross, M.D., San Francisco.
Discussion.

2:30—**Experiences Aboard the S.S. Hope in Indonesia**—Bernard M. Kramer, M.D., San Francisco.
Discussion.

3:00—**Inflammatory Blocking Agents: Their Value in Ear, Nose and Throat Diseases**—Bruce A. Sanderson, M.D., San Diego.
Discussion.

3:30—**Changing Concepts in the Indications for Operation in Cancer of the Larynx**—Robert S. Pollack, M.D., San Francisco.
Discussion.

4:00—**Vocal Nodules: A High Speed Photographic Analysis**—Henry J. Rubin, M.D., Beverly Hills.
Discussion.

4:30—**A Study of Tympanic Surgery and Its Results in a Three-Year Period**—Seymour J. Brockman, M.D., Los Angeles.
Discussion.

5:00—**Business Meeting and Election of Officers.**

PRESIDENTS' DINNER DANCE

SUNDAY, APRIL 30

Cocoanut Grove, Ambassador Hotel

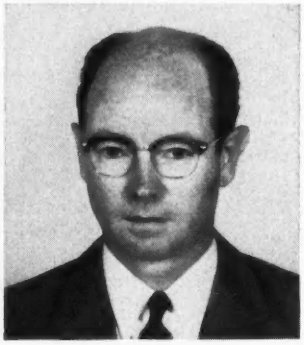
Reception, 7 p.m., Embassy Room **Dinner Dance, 8 p.m., Cocoanut Grove**

Formal dress optional

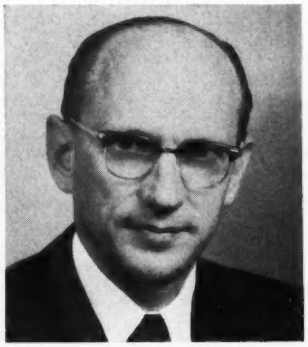
Tickets will be on sale in the Main Lobby

EYE

Chairman.....Earle H. McBain, M.D., San Rafael
Secretary.....Floyd M. Bond, M.D., San Diego
Assistant Secretary.....Richard A. Westsmith, M.D., San Mateo



EARLE H. McBAIN
Chairman



FLOYD M. BOND
Secretary

SUNDAY, APRIL 30

2:00—Regency Room, Lobby Floor

Joint Meeting with Section on Anesthesiology

2:00—A Consideration of Some Pertinent Factors Involved in the Administration of General Anesthesia for Eye Surgery—Charles P. Coman, M.D., San Diego.

Discussion by Edwin L. Glazener, M.D., San Diego.

2:30—Local Anesthesia in Ophthalmology—George L. Tabor, M.D., San Diego.

3:00—Cancer of the Eyelid Treated by Irradiation—Robert J. McKenna, M.D., and Ian Macdonald, M.D., Los Angeles.

3:30—Reopening Technique for Cicatrized Trephination—Harold F. Whalman, M.D., Los Angeles.

3:45—Medico-Legal Aspect of Contact Lenses—J. Myron Middleton, M.D., Beverly Hills.

4:15—Business Meeting and Election of Officers.

EMERGENCY CALLS AND MESSAGES

Convention Emergency Call Number: DUnkirk 1-2191—8:30 a.m. to 5:00 p.m.

(*Provided through the courtesy of the* PACIFIC TELEPHONE AND TELEGRAPH COMPANY)

Each physician should notify his own secretary regarding the *exact* section he plans to attend and the time of his attendance, and the *convention telephone number*. It is up to the individual physician to keep his own office staff so informed. The Association will *attempt* to transmit messages to the individual physician.

In case of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, HUbbard 3-1581.

INDUSTRIAL MEDICINE AND SURGERY

Chairman.....Robert C. Rossberg, M.D., Los Angeles
Secretary.....John H. Leimbach, Jr., M.D., San Francisco
Assistant Secretary.....Peter L. Hoffman, M.D., Los Angeles

ROBERT C. ROSSBERG
Chairman

JOHN H. LEIMBACH, JR.
Secretary

TUESDAY, MAY 2

2:00—East Venetian Room, Lobby Floor

Joint Meeting with Sections on General Practice and Physical Medicine

Symposium

Traumatic Injuries of the Hand from Various Viewpoints

2:00—**From the Viewpoint of Soft Tissue Injury**—Carl Nemethi, M.D., Los Angeles.
Discussion.

2:25—**From the Viewpoint of Orthopedics**—Lewis Cozen, M.D., Los Angeles.
Discussion.

2:50—**From the Viewpoint of Reconstructive Surgery of the Hand**—Herbert H. Stark, M.D., Los Angeles.
Discussion.

3:15—**From the Viewpoint of Physical Medicine**—S. Malvern Dorinson, M.D., San Francisco.
Discussion.

3:40—**From the Insurance Company Viewpoint**—Mr. John A. Montgomery, Los Angeles, by invitation.
Discussion.

4:05—**From the Viewpoint of the Industrial Accident Commission**—Mr. Jerry Crowley, Los Angeles, by invitation.
Discussion.

4:30—**Business Meeting and Election of Officers, Section on Industrial Medicine and Surgery.**

PRESIDENTS' DINNER DANCE

SUNDAY, APRIL 30

Cocoanut Grove, Ambassador Hotel

Reception, 7 p.m., Embassy Room **Dinner Dance, 8 p.m., Cocoanut Grove**

Formal dress optional

Tickets will be on sale in the Main Lobby

OBSTETRICS AND GYNECOLOGY

Chairman.....John C. McDermott, M.D., Los Angeles
Secretary.....Edward F. Healey, M.D., San Rafael
Assistant Secretary.....Kenneth Morgan, Jr., M.D., Los Angeles

JOHN C. McDERMOTT
Chairman

EDWARD F. HEALEY
Secretary

SUNDAY, APRIL 30

9:00—Regency Room, Lobby Floor

9:00—**The Use of Intranasal Oxytocin for Milk Let-Down**—Bruce D. Stern, M.D., Beverly Hills.

9:30—**Problems in the Diagnosis of Genital Tuberculosis**—Karl L. Schaupp, Jr., M.D., San Francisco.

10:00—**Myomectomy and Myometrial Reconstruction—A New Technique**—A. R. Abarbanel, M.D., Beverly Hills.

10:30—**Recess.**

10:45—**New Techniques in Pubo-Coccygeous Muscle Exercises**—Arnold H. Kegel, M.D., Los Angeles.

11:15—**Chairman's Address**—John C. McDermott, M.D., Los Angeles, Calif.

11:45—**Business Meeting and Election of Officers.**

TUESDAY, MAY 2

2:00—Regency Room, Lobby Floor

Joint Meeting with the Section on Anesthesiology

2:00— **Panel Discussion**

Anesthesia for Obstetrics

Moderator: Charles D. Anderson, M.D., Oakland

Members of the Panel:

Earnest F. Gianotti, M.D., San Francisco, Anesthesiologist.

Raymond E. Ponath, M.D., San Diego, Anesthesiologist.

William S. Kroger, M.D., Beverly Hills, Consulting Editor on Hypnosis and Psychosomatic Medicine, *Western Journal of Surgery, Obstetrics and Gynecology.*

Charles E. Weber, M.D., La Jolla, Obstetrician.

4:30—**Medical Motion Picture: Resuscitation of the Newborn.**

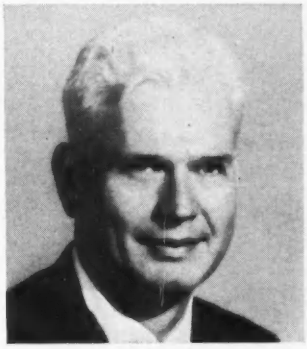
REGISTRATION

Registration and information desks are located in the Ballroom Foyer, Casino Floor. *All members, guests, and visitors are requested to register immediately on arrival.* There is no charge for registration except for Postgraduate Courses. Registration desks are open Saturday through Wednesday. *Admission to the general and section sessions and exhibit areas is by badge only.*

ORTHOPEDICS

Chairman.....Carl E. Horn, M.D., Sacramento
Secretary.....Bret W. Smart, M.D., Oakland
Assistant Secretary.....Albert H. Rodi, M.D., Los Angeles

CARL E. HORN
Chairman



BRET W. SMART
Secretary

SUNDAY, APRIL 30

9:00—Rose Room, Lobby Floor

Symposium

Rehabilitation of the Upper Extremity

9:00—**Surgery in Upper Extremity Amputees**—Robert Mazet, M.D., Los Angeles.
Discussion from the floor.

9:30—**Use of the Flexor Hinge Hand in the Severely Paralyzed—Illustrated by a Medical Motion Picture**—Vernon Nickel, M.D., Los Angeles.
Discussion from the floor.

10:00—**Intermission.**

10:20—**Upper Extremity Function After Spinal Cord Injury—Illustrated by a Medical Motion Picture**—Jacquelin Perry, M.D., Downey.
Discussion from the floor.

10:50—**Functional Bracing of the Upper Extremity**—Edwin R. Schottstaedt, M.D., San Francisco; Margaret V. Magee, R.P.T., and Elizabeth Parrish, R.P.T., San Francisco, by invitation; and George Robinson, Prosthetist, Vallejo, by invitation.
Discussion from the floor.

11:20—**Chairman's Address**—Carl Horn, M.D., Sacramento.

11:50—**Recess.**

12:30—Colonial Room, Lobby Floor

12:30—**Orthopedic Luncheon—Business Meeting and Election of Officers.**

EMERGENCY CALLS AND MESSAGES

Convention Emergency Call Number: DUnkirk 1-2191—8:30 a.m. to 5:00 p.m.

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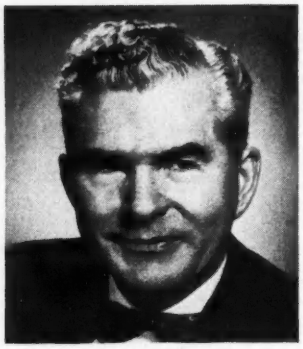
PATHOLOGY AND BACTERIOLOGY

Chairman.....Robert L. Dennis, M.D., San Jose
Secretary.....George J. Hummer, M.D., Santa Monica
Assistant Secretary...Carl M. McCandless, Jr., M.D., San Francisco



ROBERT L. DENNIS
Chairman

GEORGE J. HUMMER
Secretary

SUNDAY, APRIL 30

9:00—East Venetian Room, Lobby Floor

9:00—**Hemagglutination Technique Applied for the Detection of Hormones and Their Antibodies**—Edward R. Arquilla, M.D., Los Angeles, by invitation.

9:20— Discussion.

9:25— **Symposium**

Blood Coagulation Problems from the Standpoints of Clinician and Pathologist

Robert R. Proctor, M.D., Los Angeles; Benjamin G. Fishkin, M.D., Los Angeles, and Donald Bernstein, M.D., Santa Monica, both by invitation.

10:30— Discussion—Irwin Nydick, M.D., New York City, and Alvin Lewis, M.D., San Francisco; followed by general discussion.

10:50—**Intermission.**

Joint Meeting with the Section on Internal Medicine

11:00—**Serum Enzymes in Disease**—Earl Benditt, M.D., Seattle, by invitation.

11:25— Discussion.

11:30—**Serum Enzyme Patterns as Aids in the Diagnosis of Disease**—Irwin Nydick, M.D., New York City, by invitation.

11:55— Discussion.

12:00—**Steroid and Gonadotropin Hormone Patterns in Certain Clinical Disorders**—Gerson R. Biskind, M.D., San Francisco.

12:25— Discussion.

12:30—**Automation in the Clinical Laboratory**—Thomas Feichtmeir, M.D., and Daniel M. Baer, M.D., San Francisco.

12:55—**Business Meeting and Election of Officers.**

BRING PROPER IDENTIFICATION FOR REGISTRATION

PEDIATRICS

Chairman.....James L. Dennis, M.D., Oakland
Secretary.....Harry O. Ryan, M.D., Pasadena
Assistant Secretary.....R. Bruce Jessup, M.D., Palo Alto

JAMES L. DENNIS
Chairman

HARRY O. RYAN
Secretary

WEDNESDAY, MAY 3

2:00—Oval Room A, Casino Floor

2:00—Newer Concepts in the Management of Tetanus—Thomas C. Cock, M.D., Berkeley.

2:25—The Fibrinolytic Enzyme Defect in Hyaline Membrane Disease—Jack Lieberman, M.D., Long Beach.

2:50—The Significance of Hypernatremia in Pediatric Practice—Virginia Y. Blacklidge, M.D., Oakland, by invitation.

3:15—Recess.

3:30—The Use of Thioridazine Hydrochloride (Mellaril®) in the Treatment of Children's Behavior Disorders—Leon Oettinger, Jr., M.D., San Marino.

3:55—Perirenal Hematoma in the Newborn—Victor G. Mikity, M.D., Los Angeles.

4:20—Chairman's Address: The Thorny Child—James L. Dennis, M.D., Oakland.

4:45—Business Meeting.

PRESIDENTS' DINNER DANCE

SUNDAY, APRIL 30

Cocoanut Grove, Ambassador Hotel

Reception, 7 p.m., Embassy Room **Dinner Dance, 8 p.m., Cocoanut Grove**

Formal dress optional

Tickets will be on sale in the Main Lobby

PHYSICAL MEDICINE

Chairman.....Joseph E. Maschmeyer, M.D., Los Angeles
Secretary.....S. Malvern Dorinson, M.D., San Francisco
Assistant Secretary.....Karl H. Haase, M.D., Los Angeles

JOSEPH E. MASCHMEYER
Chairman

S. MALVERN DORINSON
Secretary

TUESDAY, MAY 2

9:00—Lido Room, Lobby Floor

9:00—**Introduction**—Joseph E. Maschmeyer, M.D., Chairman, Section on Physical Medicine, Los Angeles.

9:05—**Fasciculation: Electromyograph and Clinical Significance**—Robert V. Miller, Jr., M.D., Beverly Hills.

9:30—**Diagnosis of Low Back Pain**—John McM. Mennell, M.D., Los Angeles, by invitation.

9:55—**Physical Treatment of Low Back Pain**—O. Leonard Huddleston, M.D., Santa Monica.

10:20—**Recess.**

10:30—**Physical Muscle Relaxants**—E. C. Christensen, M.D., Loma Linda.

10:55—**Therapeutic Exercise in General Practice**—Miquel J. Rodriguez, M.D., Los Angeles, by invitation.

11:20—**The Upright Posture in Patients with Involvement of the Spinal Cord**—Roy H. Nyquist, M.D., Long Beach.

11:45—**Business Meeting.**

TUESDAY, MAY 2

2:00—East Venetian Room, Lobby Floor

Joint Meeting with Sections on General Practice and Industrial Medicine

Symposium

Traumatic Injuries of the Hand from Various Viewpoints

2:00—**From the Viewpoint of Soft Tissue Injury**—Carl Nemethi, M.D., Los Angeles.
Discussion.

2:25—**From the Viewpoint of Orthopedics**—Lewis Cozen, M.D., Los Angeles.
Discussion.

2:50—**From the Viewpoint of Reconstructive Surgery of the Hand**—Herbert H. Stark, M.D., Los Angeles.
Discussion.

3:15—**From the Viewpoint of Physical Medicine**—S. Malvern Dorinson, M.D., San Francisco.
Discussion.

3:40—**From the Insurance Company Viewpoint**—Mr. John A. Montgomery, Los Angeles, by invitation.
Discussion.

4:05—**From the Viewpoint of the Industrial Accident Commission**—Mr. Jerry Crowley, Los Angeles, by invitation.
Discussion.

BRING PROPER IDENTIFICATION FOR REGISTRATION

PSYCHIATRY AND NEUROLOGY

Chairman.....Leon J. Whitsell, M.D., San Francisco
Secretary.....Robert E. Wyers, M.D., Norwalk
Assistant Secretary.....Mark Zeifert, M.D., Fresno

LEON J. WHITSELL
Chairman

ROBERT E. WYERS
Secretary

WEDNESDAY, MAY 3

9:00—Regency Room, Lobby Floor

Neurology

9:00—**Correlation of Clinical and Pathological Findings in Cerebral Palsy**—Peter Cohen, M.D., San Francisco.

Discussant: Cyril B. Courville, M.D., Los Angeles.

9:30—**Lobotomy After Sixty-Five**—Walter Freeman, M.D., Ph.D., Los Altos.

Discussant: Richard E. Turk, M.D., Berkeley.

10:00—**Treatment of Bell's Palsy With Prednisone**—Stuart H. Mann, M.D., San Diego, by invitation.

Discussant: Ralph W. Baris, M.D., La Jolla.

10:30—**Mechanisms of Headache, Vascular and Muscular**—Arnold P. Friedman, M.D., New York City, by invitation.

Discussant: J. M. Nielsen, M.D., Los Angeles.

11:00—**Chairman's Address: Neurologic Complications of Diabetes**—Leon J. Whitsell, M.D., San Francisco.

11:30—**Recess.**

11:40—**Business Meeting.**

WEDNESDAY, MAY 3

2:00—Regency Room, Lobby Floor

Psychiatry

2:00—**Effect of D-Amphetamines on Speech Defects in the Mentally Retarded**—Charles H. Fish, M.D., and Evelyn Bowling, Costa Mesa, both by invitation.

Discussant: Ronald Koegler, M.D., Los Angeles.

2:30—**The Psychiatric Management of Intersexed Patients**—Robert J. Stoller, M.D., Los Angeles; and Harold Garfinkel, Ph.D., and Alexander Rosen, Ph.D., Los Angeles, both by invitation.

Discussion.

3:00—**Transference to a Medical Center**—Harry A. Wilmer, M.D., Palo Alto.

Discussion.

3:30—**The Geriatric Mental Patient**—G. E. Wolff, M.D., Camarillo, by invitation.

Discussant: Jerome Kummer, M.D., Santa Monica.

4:00—**Problem of Obscenity and Pornography**—Karl M. Bowman, M.D., San Francisco and Bernice Engle, M.A., San Francisco, by invitation.

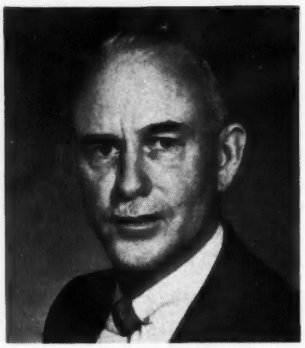
Discussion: Edward Stainbrook, M.D., Los Angeles.

4:30—**The Psychiatric Clinic and the Delinquent Adolescent**—Edward G. Colbert, M.D., Santa Monica.

Discussant: William Glasser, M.D., West Los Angeles.

PUBLIC HEALTH

Chairman.....Merle E. Cosand, M.D., San Bernardino
Secretary.....Ellis D. Sox, M.D., San Francisco
Assistant Secretary.....Irving D. Litwack, M.D., Long Beach



MERLE E. COSAND
Chairman

ELLIS D. SOX
Secretary

WEDNESDAY, MAY 3

2:00—East Venetian Room, Lobby Floor

2:00—Skin Testing in Schools—An Important Part of the Community Case-Finding Program—Francis J. Curry, M.D., San Francisco.
Discussion.

2:30—Seat Belts and the Public Health—Herbert A. Lints, M.D., Escondido.
Discussion.

3:00—Where Is Public Health Medical Care for Children Going?—Leslie Corsa, Jr., M.D., Berkeley; and Robert B. Jessup, M.D., Berkeley.
Discussion.

3:30—Recess.

3:40—Medical Team Approach to Alcoholism—Nicholas J. Khoury, M.D., Los Angeles.
Discussion.

4:10—Radiation Protection—A Public Health Responsibility—George M. Uhl, M.D., Los Angeles; and Jack C. Rogers, B.S.C.E., Los Angeles, by invitation.

4:40—Business Meeting.

PRESIDENTS' DINNER DANCE

SUNDAY, APRIL 30

Cocoanut Grove, Ambassador Hotel

Reception, 7 p.m., Embassy Room **Dinner Dance, 8 p.m., Cocoanut Grove**

Formal dress optional

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RADIOLOGY

Chairman.....Frank C. Binkley, M.D., Pasadena
Secretary.....John R. Bryan, M.D., San Francisco
Assistant Secretary.....Robert L. Scanlan, M.D., Los Angeles

FRANK C. BINKLEY
Chairman

JOHN R. BRYAN
Secretary

SUNDAY, APRIL 30

9:00—Lido Room, Lobby Floor

Diagnostic Radiology

9:00—**Selectivity in the Study of the Cardiovascular System**—Herbert L. Abrams, M.D., Palo Alto, by invitation.
Discussion.

9:25—**Lymphosarcoma of the Colon and Rectum**—John H. Woodruff, Jr., M.D., Los Angeles; and Alan B. Skorneck, M.D., Los Angeles, by invitation.
Discussion.

9:50—**Performing the Barium Enema**—Howard L. Steinbach, M.D., San Francisco.
Discussion.

10:15—**Recess.**

10:25—**Parosteal Osteosarcomata** — Charles P. Schwinn, M.D., and Robert L. Scanlan, M.D., Los Angeles.
Discussion.

10:50—**Arthrography of the Knee**—Saul Heiser, M.D., Los Angeles.
Discussion.

11:15—**The Radiologic Diagnosis of Subfrontal Tumors**—Alfred L. Schmitz, M.D., Los Angeles.
Discussion.

11:40—**Business Meeting and Election of Officers.**

SUNDAY, APRIL 30

2:00—Lido Room, Lobby Floor

Therapeutic Radiology

2:00—**Mediastinal Hodgkin's Disease**—Jerome M. Vaeth, M.D., and Franz J. Buschke, M.D., San Francisco.
Discussion.

2:25—**New Aspects of Dosage Nomenclature and Calculation**—Robert E. Pugh, Jr., Ph.D., Los Angeles, by invitation.
Discussion.

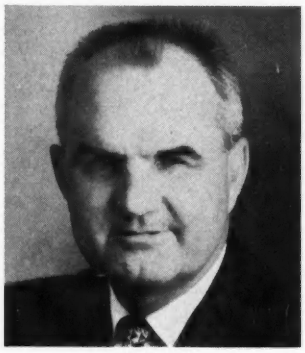
2:30—**Recess—Annual Meeting of Pacific Roentgen Society.**

VISIT SCIENTIFIC AND TECHNICAL EXHIBITS

UROLOGY

Chairman.....Morrell E. Vecki, M.D., San Francisco
Secretary.....Sam Peck, M.D., San Diego
Assistant Secretary.....Harold Kay, M.D., Oakland

MORRELL E. VECKI
Chairman



SAM PECK
Secretary

WEDNESDAY, MAY 3

9:00—Grove Lounge, Lobby Floor

9:00—**Peripelvic Renal Cysts**—Miguel A. Llanos, M.D., Los Angeles.
Discussion.

9:15—**Excretory Urethrography—An Adjunct in Urologic Diagnosis** — Robert O. Pearman, M.D., Encino.
Discussion.

9:30—**Does the Catheter-Free State Bear Watching Among the Patients With Spinal Cord Injury?** —A. Estin Comarr, M.D., Long Beach.
Discussion by E. Vincent Moore, Jr., M.D., La Mesa.

9:45—**Actinomycosis of the Kidney**—Harold Kay, M.D., Oakland.
Discussion.

10:00—**Intermission.**

10:10— **Panel Discussion**

Biopsy of the Prostate

Moderator: Frank J. Hinman, Jr., M.D., San Francisco

10:10—**Biopsy of the Prostate**—Ralph J. Veenema, M.D., Assistant Professor of Clinical Urology, Columbia University College of Physicians and Surgeons, New York City, by invitation.

10:40—**Panel Discussion: When, How, and Under What Circumstances Should the Prostate Be Biopsied?**

Panelists: Ralph J. Veenema, M.D., New York City; Roger W. Barnes, M.D., Los Angeles; Robert J. Prentiss, M.D., San Diego; Joseph J. Kaufman, M.D., Los Angeles; Alex L. Finkle, M.D., San Francisco.

12:00—**Question and Answer Period.**

WEDNESDAY, MAY 3

2:00—Grove Lounge, Lobby Floor

2:00—**Carcinoma of Cowper's Gland—Report of the Eleventh Case**—Ector LeDuc, M.D., San Diego.
Discussion by Earl F. Nation, M.D., Pasadena.

2:15— **Panel Discussion**

Vesico-Vaginal Fistula

Moderator: Donald A. Charnock, M.D., Los Angeles

2:15—**Vesico-Vaginal Fistula**—Virgil S. Counseller, M.D., Phoenix, by invitation.

2:25—**Panel Discussion.**

Panelists: Virgil S. Counseller, M.D., Phoenix; Elmer Belt, M.D., Los Angeles; Henry M. Weyrauch, M.D., San Francisco; John W. Dorsey, M.D., Los Angeles.

3:45—**Business Meeting: Chairman's Address and Election of Officers.**

3:55—**Adjournment** to West Venetian Room for Urological Film Symposium.

West Venetian Room, Lobby Floor

4:00—**Urological Film Symposium:**

1. **Undescended Testicle: Surgical Anatomy of the Spermatic Vessels, Spermatic Surgical Triangles, and Lateral Spermatic Ligament** —Robert J. Prentiss, M.D., San Diego.
2. **The Repair of Vesico-Vaginal Fistula by the Transperitoneal, Transvesical Approach** —John W. Dorsey, M.D., Long Beach.
3. **Transvaginal Repair of Vesico-Vaginal Fistula**—Elmer Belt, M.D., Los Angeles.

Scientific and Organizational Exhibits

SCIENTIFIC EXHIBITS

Venetian Room Foyer, South End of Lobby

Diagnosis and Treatment of Peripheral Arteriosclerosis—Travis Winsor, M.D., Los Angeles.—Through the use of charts and posters, photographs and drawings this exhibit shows the diagnosis and treatment of peripheral vascular disease, using medical and surgical methods.

The Physicians' Roles in a Rehabilitation Program—John C. Wilcox, M.D., Pomona.—A series of four or five cases depicting several aspects of the organization of a medically orientated rehabilitation program. Emphasis is given to the importance of medical direction and participation by the personal physician and the rehabilitation physician in both the organization of a general physical rehabilitation program and the assignment of particular parts in it.

Pathogenesis and Treatment of Ulcerative Colitis—Hypersensitivity Factors—J. Alfred Rider, M.D., San Francisco.—This exhibit consists of drawings, photographs and photomicrographs that describe and illustrate clinical features of ulcerative colitis, etiological factors and experimental data implicating hypersensitivity factors, and treatment of ulcerative colitis.

Stereotaxic Transsphenoidal Yttrium 90 Hypophysectomy—Paul H. Crandall, M.D., Los Angeles.—A display of drawings, roentgenograms, charts and posters, photomicrographs, etc., in two parts, showing a stereotaxic device for implantation of intrasellar radioactive beads. The steps in the procedure are shown. The dosimetry calculations and results in a series of patients are given.

Superficial Chemosurgery in the Treatment of Aging Skin—Samuel Ayres, III, M.D., Los Angeles.—The beneficial effects of the careful application of chemical cauterants to actinically damaged and aging skin is demonstrated by means of posters and photographs.

Forensic Pathology and Primary Intracranial Tumors—Robert W. Huntington, Jr., M.D., Bakersfield.—This exhibit, consisting of charts, posters and photographs is based on cases studied by the offices of the Kern County Coroner and the Kern County Pathologist, in which the solution to a medicolegal problem proved to be a primary intracranial neoplasm. The range of problems included possible and actual trauma, gross behavior disturbance, and mysterious and unattended death. The exhibit outlines the problem in each case, presents the autopsy findings, with gross and microphotographs.

Drugs in Emotional Disorders: Past and Present—Leo E. Hollister, M.D., Palo Alto.—This exhibit is made up of charts and posters to illustrate the aims of drug therapy in the past and present. Examples of agents used during the past twenty years are listed. Charts also show chemical structure of drugs used currently. Present theory is diagrammed and therapeutic results obtained in a hospital are given. Anti-depressants and psychotomimetics agents are mentioned as future agents of therapeutic value.

Check Your Eye-Cue—George K. Kambara, M.D., Los Angeles.—An exhibit containing five faces made out of plaster of paris. The right eye of each face has a fundus photograph or drawing which can be viewed with ophthalmoscope provided on the left hand side. Below the face is a panel which gives the answer of the systemic disease represented. This will be covered and can be opened to get the answer. The two side panels contain transparencies of fundus photographs entitled "Fundus Findings in Systemic Disease Commonly Seen" and "Fundus Findings in Systemic Disease Infrequently Seen."

The Circulation During Hypotension (Shock)—Max H. Weil, M.D., Los Angeles.—A functioning model of the cardiovascular system which simulates the human circulation to illustrate the way in which the flow of blood and blood pressure are maintained. The purpose of this exhibit is to translate the abnormal physiological events that lead to and maintain shock into a mechanical analogy. The relative roles of heart rate, blood pressure, blood flow and blood volume in the causation and progress of shock are demonstrated.

ORGANIZATIONAL EXHIBITS

Committee on Careers in Nursing, California League of Nursing—A Committee representative will be on hand to explain a state-wide program to interest more qualified people in entering accredited schools of nursing, professional and vocational; allied health careers; and graduate nurse career development. A consultant in materials will be available at the Careers booth.

California Medical Association Physician Placement Service — The California Medical Association's Placement Service booth will be distributing "Opportunities" bulletins and other information on how to make the best use of the Placement Service facilities. The Coordinator of the Placement Service will interview persons who have openings or who are looking for opportunities.

California Physicians' Service—Blue Shield—At the California Physicians' Service booth, professional relations representatives will be on hand throughout the meeting to discuss any phase of the C.P.S. operation. Descriptive materials, fee schedules, and other information to physicians' offices will be available for distribution.

MOTION PICTURE PROGRAM

PAUL D. FOSTER, M.D., Chairman

Sunday to Wednesday, April 30 to May 3

WEST VENETIAN ROOM, AMBASSADOR HOTEL

Motion Picture Film Symposiums will be offered daily in the West Venetian Room, Ambassador Hotel. Each Symposium will have a Moderator and a Panel of experts in the field (authors in many cases) to discuss films and answer questions from the audience. Following is a tentative list of films which will be shown on the programs. A separate Motion Picture program with complete listing and description of films will be available at the time of the meeting.

SUNDAY, 2:00-3:45 P.M.

Obstetrics

Moderator: Edward F. Healey, M.D., San Rafael.

Panel: Authors William S. Kroger, M.D., Beverly Hills; Keith P. Russell, M.D., Los Angeles.

Breech Delivery.

Resuscitation of the Newborn.

Modern Obstetrical Management.

Hypnoanesthesia in Obstetrics.

SUNDAY, 3:50-5:30 P.M.

Gynecology

Moderator: Paula Horn, M.D., Los Angeles.

Panel: Authors H. Wright Seiger, M.D., Santa Monica; Earl Hyman, M.D., Beverly Hills; Henry J. Muller, M.D., San Francisco.

Cold Coning of the Uterine Cervix.

Vaginal Hysterectomy.

Schauta Vaginal Hysterectomy.

Investigation of Female Sterility.

SUNDAY, 8:00-10:00 P.M.

Panel: William Mumler, M.D., Los Angeles; Joseph O'Connor, M.D., Pasadena.

Rheumatic Heart Disease.

Chronic Bronchitis.

Bronchial Carcinoma.

MONDAY, 9:00-12:00 NOON

Medicine

Moderator: William H. Grishaw, M.D., Beverly Hills.

Panel: Paul Ewing, M.D., Northridge; Allen T. Hinman, M.D., San Francisco.

Hypertension I (The Regulation of Blood Pressure).

Current Trends in the Clinical Management of Diabetes.

Physical Diagnosis—Communicable Disease.

Early Detection and Medical Management of Ulcerative Colitis.

MONDAY, 2:00-5:00 P.M.

Hernias

Moderator: Samuel R. Sherman, M.D., San Francisco.

Panel: Philip R. Westdahl, M.D., San Francisco; Malcolm C. Todd, M.D., Long Beach.

Recurrence in Inguinal Hernia.

Femoral Hernia.

Inguinal Hernioplasty.

Diaphragmatic Hernia in the Newborn.

Ventral Hernia.

MONDAY, 8:00-10:00 P.M.

Allergy

Moderator: Hyman Miller, M.D., Beverly Hills.

Panel: Willard Small, M.D., Pasadena; Gildon Beall, M.D., Los Angeles.

Clinical Management of Autoimmune Hematologic Disorders.

Anaphylaxis and Allergy.

TUESDAY, 9:00-12:00 NOON

Abdominal Surgery

Moderator: William Quinn, M.D., Los Angeles.

Panel: R. Bruce Henley, M.D., Oakland; David Schmidt, M.D., Los Angeles.

Complications of Acute Appendicitis.

Strangulated Obstruction of the Intestine.

Peritonitis—Some Causes and Management.

The Peritoneum: Reactions to Operative Trauma and Their Control.

Fecal Fistulae Following Appendectomy.

TUESDAY, 2:00-3:30 P.M.

Moderator: Gurth Carpenter, M.D., Beverly Hills.

Panel: Charles L. Schneider, M.D., Professor of Obstetrics and Physiology, University of Michigan, Ann Arbor; J. Garrott Allen, M.D., Chairman of Surgery, Stanford University.

Premiere: Blood Fractions in Clinical Medicine.

TUESDAY, 3:30-5:00 P.M.

Bleeding

Why Johnny Bleeds.

A Case of Unexplained Bleeding from Upper Gastrointestinal Tract.

Clinical Management of Autoimmune Hematologic Disorders.

TUESDAY, 8:00-10:00 P.M.

Alcoholism.

Chemical Tests for Intoxication.

Discussants: Theodore Curphey, M.D., Los Angeles; Mandel Sherman, M.D., Beverly Hills; Mr. William Whelan, San Francisco.

Adenomammectomy—Breast Fillet.

Discussion by Author, Paul A. Kaufman, M.D., Beverly Hills.

I Dress the Wound.

WEDNESDAY, 9:00-12:00 NOON

Pediatrics

Moderator: Harry O. Ryan, M.D., Pasadena.

Panel: Milton Van Dyke, M.D., Long Beach; Stephan van Adelsberg, M.D., Los Angeles.

Management of Breast Feeding.

Neurological Examination of the Newborn.

Intestinal Obstruction in the Newborn and Infant.

Pediatric Gynecology.

WEDNESDAY, 2:00-3:50 P.M.

General Urology

Panel: Jay J. Crane, M.D., Los Angeles; Samuel Bacon, M.D., Hollywood.

Surgical Correction of Male Sterility.

Urinary Calculi.

Surgical Treatment of Renovascular Hypertension.

WEDNESDAY, 4:00-5:00 P.M.

Urology

Moderator: Sam Peck, M.D., San Diego.

Panel: Authors John W. Dorsey, M.D., Long Beach; Robert J. Prentiss, M.D., San Diego; Elmer Belt, M.D., Los Angeles.

Undescended Testicle: Surgical Anatomy of Spermatic Vessels, Spermatic Surgical Triangles and Lateral Spermatic Ligament.

The Repair of Vesico-Vaginal Fistula by the Transperitoneal Transvesical Approach.

Transvaginal Repair of Vesico-Vaginal Fistula.

QUALIFICATIONS/REQUIREMENTS FOR REGISTRATION

(a) All M.D.'s with credentials showing that they hold valid license to practice medicine. (Membership card in C.M.A.; county medical society/association or A.M.A. membership card.)

(b) Medical students will be admitted upon presentation of credentials from their medical schools identifying them as medical students. (A membership card of the Student American Medical Association or letter from their dean's office.)

(c) Medical secretaries will be admitted upon presentation of a letter from the physician employer.

(d) Pharmacist mates and other military personnel of a like grade will be admitted upon presentation of a letter requesting their admittance, written by their commanding officer.

(e) Dentists (D.D.S.), doctors of veterinary medicine (D.V.M.), registered nurses (R.N.), student nurses, x-ray technicians, laboratory technicians, dietitians, allied public health personnel, and others will be admitted provided they have proper identification.

(f) *All questions on admission will be passed upon by a member of the Committee on Registration who will be present at the desk.*

POSTGRADUATE COURSES

Presented by the California Medical Association in cooperation with the College of Medical Evangelists and the University of Southern California

Out-of-State Faculty—Guests of the California Medical Association

IRWIN NYDICK, M.D., Assistant Professor of Clinical Medicine, Cornell University Medical College, and Research Fellow, Sloan-Kettering Institute, New York.

HENRY J. TUMEN, M.D., Professor and Chairman of the Department of Medicine, Graduate School of Medicine, University of Pennsylvania.

1. CLINICAL NEUROLOGY

Sunday, Monday and Tuesday, April 30, May 1 and 2, 1961

Amphitheater, White Memorial Hospital, 1700 Brooklyn Avenue, Los Angeles

Program planned by the College of Medical Evangelists, Department of Neurology.

Time: Sunday, April 30, 9:00 a.m. to 12:00 noon; Monday and Tuesday, May 1 and 2, 2:00 p.m. to 5:00 p.m.

Fee: $25.00.

8:00 a.m. Sunday—Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to White Memorial Hospital.

Instructional Staff (from College of Medical Evangelists unless otherwise noted):

E. W. Beehler, M.D., Instructor in Neurosurgery.
Cyril B. Courville, M.D., Professor of Neurology.
Laurence Jacobs, M.D., Assistant Clinical Professor of Neurology.
Leslie B. Mann, M.D., Associate Professor of Neurology.
J. M. Nielsen, M.D., Clinical Professor of Medicine (Neurology), UCLA School of Medicine.
Clarence W. Olsen, M.D., Clinical Professor of Neurology.
Erling S. Tobiassen, M.D., Associate Professor of Radiology.

SUNDAY, APRIL 30

Chairman of the Day: Cyril B. Courville, M.D.

8:00 a.m.—***Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to White Memorial Hospital.***

9:00—**Brief Review of the Anatomy and Physiology of the Brain and Spinal Cord**—Cyril B. Courville, M.D.

10:00—**Neurological Signs and Their Significance**—J. M. Nielsen, M.D.

11:00—**Hyperkinetic Phenomena and Their Medical and Surgical Treatment**—L. B. Mann, M.D., and E. W. Beehler, M.D.

MONDAY, MAY 1

Chairman of the Day: C. W. Olsen, M.D.

2:00—**Headaches, Diagnosis and Treatment**—Cyril B. Courville, M.D.

3:00—**Strokes, Diagnosis**—C. W. Olsen, M.D.

4:00—**Strokes, Treatment**—Laurence Jacobs, M.D.

TUESDAY, MAY 2

Chairmen of the Day: C. W. Olsen, M.D., and L. B. Mann, M.D.

2:00—**Convulsions, Diagnosis and Management—EEG as an Aid**—Leslie B. Mann, M.D.

3:15—**Diagnosis of Everyday Lesions of the Skull and Spine**—Erling S. Tobiassen, M.D.

4:00—**Application of Laboratory Procedures to Neurological Problems**—C. W. Olsen, M.D.

2. USE AND LIMITATIONS OF LABORATORY TESTS

Saturday and Sunday, April 29 and 30, 1961

New Auditorium (Room 1645), Los Angeles County Hospital, 1200 N. State Street, Los Angeles

Program planned by the University of Southern California School of Medicine—Phil R. Manning, M.D., Associate Dean, Postgraduate Division.

Time: Saturday, April 29, 9:00 a.m. to 12:00 noon; 1:30 p.m. to 5:00 p.m.; Sunday, April 30, 9:00 a.m. to 12:00 noon.

Fee: $25.00.

8:00 a.m. daily—Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to Los Angeles County General Hospital.

Instructional Staff:

California Medical Association Guests:

Irwin Nydick, M.D., Assistant Professor of Clinical Medicine, Cornell University Medical College and Research Fellow, Sloan-Kettering Institute, New York.

Henry J. Tumen, M.D., Professor and Chairman of the Department of Medicine, Graduate School of Medicine, University of Pennsylvania.

University of Southern California School of Medicine (unless otherwise noted):

Clarence M. Agress, M.D., Associate Clinical Professor of Medicine—UCLA.

William Bachrach, M.D., Associate Clinical Professor of Medicine.

Benjamin Barbour, M.D., Instructor in Medicine.

David H. Blankenhorn, M.D., Assistant Professor of Medicine.

Boris Catz, M.D., Associate Clinical Professor of Medicine.

Thomas P. Dowling, M.D.

Ernest Gold, M.D., Assistant Professor of Medicine.

Bernard J. Haverback, M.D., Assistant Professor of Medicine.

Richard J. Henry, M.D., Adjunct Associate Professor of Biochemistry.

Irwin Hoffman, M.D., Assistant Clinical Professor of Medicine.

Ralph E. Homann, M.D., Clinical Professor of Medicine.

Helen E. Martin, M.D., Professor of Medicine.

Donald W. Petit, M.D., Associate Professor of Medicine.

Emmett Reilly, M.D., Assistant Clinical Professor of Pathology.

Edward Shapiro, M.D., Clinical Professor of Medicine.

Arnold G. Ware, Ph.D., Professor of Biochemistry and Nutrition.

Maurice Yettra, M.D., Associate Clinical Professor of Medicine.

Program Coordinators: Donald W. Petit, M.D. and Edward Shapiro, M.D.

SATURDAY, APRIL 29

8:00 a.m.—*Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to Los Angeles County General Hospital.*

9:00-9:30—**Common Laboratory Errors**—Arnold G. Ware, Ph.D.

9:30-10:00—**Cost Accounting of the Laboratory**—Edward Shapiro, M.D.

10:00-10:30—**Coffee Break.**

10:30-12:00—**The Laboratory in the Diagnosis of Hematology.**

Moderator—Donald W. Petit, M.D.

Maurice Yettra, M.D., Arnold G. Ware, Ph.D., Emmett Reilly, M.D.

12:00-1:30—**Lunch.**

1:30-3:00—**Laboratory Diagnosis of Heart Disease.**

Moderator—Edward Shapiro, M.D.

Irwin Hoffman, M.D., David H. Blankenhorn, M.D., Clarence M. Agress, M.D., Irwin Nydick, M.D.

3:00-3:30—**Coffee Break.**

3:30-5:00—**The Laboratory Diagnosis in Renal Diseases and Electrolyte Problems.**

Moderator—Edward Shapiro, M.D.

Helen E. Martin, M.D., Ralph E. Homann, M.D., Benjamin Barbour, M.D.

SUNDAY, APRIL 30

8:00 a.m.—*Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to Los Angeles County General Hospital.*

9:00-10:30—**The Use of the Laboratory in Diagnosing Diseases of Liver, Gallbladder and Pancreas.**

Moderator—Donald W. Petit, M.D.

William Bachrach, M.D., Richard J. Henry, M.D., Bernard J. Haverback, M.D., Henry J. Tumen, M.D.

10:30-10:45—**Coffee Break.**

10:45-12:15—**The Laboratory in the Diagnosis of Endocrine Disturbances.**

Moderator—Donald W. Petit, M.D.

Boris Catz, M.D., Tom Dowling, M.D., Ernest Gold, M.D., Richard J. Henry, M.D.

3. PRACTICAL GYNECOLOGY

Saturday and Sunday, April 29 and 30, 1961

McKibben Hall Auditorium, Medical School Campus, 2025 Zonal Avenue, Los Angeles

Program planned by the University of Southern California School of Medicine—Phil R. Manning, M.D., Associate Dean, Postgraduate Division.

Time: Saturday, April 29, 9:00 a.m. to 12:00 noon; 1:30 p.m. to 5:00 p.m.; Sunday, April 30, 9:00 a.m. to 12:00 noon.

Fee: $25.00.

8:00 a.m. daily—Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to USC School of Medicine.

Instructional Staff:

James C. Caillouette, M.D., Instructor in Obstetrics and Gynecology.

Lester T. Hibbard, M.D., Associate Clinical Professor in Obstetrics and Gynecology.

Edward G. Jones, M.D., Associate Clinical Professor in Obstetrics and Gynecology.

Charles F. Langmade, M.D., Associate Clinical Professor in Obstetrics and Gynecology.

George A. Macer, M.D., Assistant Clinical Professor of Obstetrics and Gynecology.

James M. Maharry, M.D., Instructor in Obstetrics and Gynecology.
Robert M. McVann, M.D., Assistant Clinical Professor in Obstetrics and Gynecology.
John J. Molitor, M.D., Instructor in Obstetrics and Gynecology.
James F. Nolan, M.D., Associate Clinical Professor in Obstetrics and Gynecology.
Robert A. Sack, M.D., Instructor in Obstetrics and Gynecology.
Richard Taw, M.D., Associate Clinical Professor in Obstetrics and Gynecology.
Alexander Varga, M.D., Instructor in Obstetrics and Gynecology.
A. N. Webb, M.D., Associate Clinical Professor of Obstetrics and Gynecology.

SATURDAY, APRIL 29

8:00 a.m. daily—*Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to USC School of Medicine.*

Welcoming Address—Erle Henriksen, M.D., *Program Coordinator.*

MORNING SESSION—James F. Nolan, M.D., *Presiding.*

9:00-9:40—**The Office Diagnosis of Gynecological Malignancies**—Edward G. Jones, M.D.

9:40-10:20—**New Drugs in the Management of Pelvic Malignancies**—Alexander Varga, M.D.

10:20-10:40—**Coffee Break.**

10:40-11:20—**The Management of Cervical and Endometrial Cancer**—John J. Molitor, M.D.

11:20-12:00—**Blood Transfusions**—Robert Sack, M.D.

Question and Answer Session follows each lecture.

12:00-1:30—**Lunch**

AFTERNOON SESSION—A. N. Webb, M.D., *Presiding.*

1:30-2:10—**Pelvic Inflammatory Disease, Diagnosis and Management**—Charles Langmade, M.D.

2:10-2:50—**The Management of Sepsis**—James C. Caillouette, M.D.

2:50-3:05—**Coffee Break.**

3:05-3:45—**Extra Uterine Pregnancies**—Lester T. Hibbard, M.D.

3:45-4:25—**Leukorrhea**—James M. Maharry, M.D.

4:25-5:00—**The Stein-Leventhal Syndrome**—Robert McVann, M.D.

Question and Answer Session follows each lecture.

SUNDAY, APRIL 30

8:00 a.m. daily—*Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to USC School of Medicine.*

George Macer, M.D., *Presiding*

9:00-9:45—**The Indications for Hormonal Therapy in Gynecology**—Richard Taw, M.D.

9:45-10:00—**Coffee Break.**

10:00-12:00—**"What Would You Do?"**

Richard Taw, M.D., Edward G. Jones, M.D., Charles Langmade, M.D., James F. Nolan, M.D., Lester T. Hibbard, M.D.

4. CARDIAC RESUSCITATION—Two All-inclusive Sessions*

Raulston Building (Room 211), USC School of Medicine, 2025 Zonal Avenue, Los Angeles

Program planned by the University of Southern California School of Medicine—Phil R. Manning, M.D., Associate Dean, Postgraduate Division.

Time: April 29, 9:00 to 11:00 a.m.; April 30, 2:00 to 4:00 p.m.

Fee: $30.00 each Session.

8:00 a.m. Saturday—Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to USC School of Medicine.

*Each Session limited to 15 registrants from areas other than San Francisco or Los Angeles.

SATURDAY, APRIL 29—SESSION I

8:00 a.m. Saturday—*Chartered bus leaves Wilshire entrance of Ambassador Hotel to go to USC School of Medicine.*

9:00-11:00—William P. Mikkelsen, M.D., Associate Clinical Professor of Surgery.

SUNDAY, APRIL 30—SESSION II

2:00-4:00—William R. Smith, M.D., Instructor in Surgery.

The course offers practical instruction on cardiac compression, the use of electrical stimulation or injection of drugs into the heart in the case of ventricular standstill or arrest in surgery. It is based on accepted methods used successfully here and in other medical centers.

WOMAN'S AUXILIARY *to the* CALIFORNIA MEDICAL ASSOCIATION

Thirty-First Annual Convention, April 30 to May 2, 1961

Headquarters: Ambassador Hotel, Los Angeles

MRS. SAMUEL GENDEL, President

MRS. LAWRENCE CUSTER, President-Elect

Convention Chairman: MRS. SAMUEL K. BACON
Convention Co-Chairman: MRS. ALBERT F. STELHORN

REGISTRATION

Main Lobby

Sunday, April 30.....8:30 a.m. to 4:00 p.m.
Monday, May 1.....8:30 a.m. to 4:00 p.m.
Tuesday, May 2.....8:30 a.m. to 10:00 a.m.

SATURDAY, APRIL 29

4:00 p.m.—Annual Report of the Woman's Auxiliary by the President, Mrs. Samuel Gendel, to the California Medical Association House of Delegates, Embassy Room. All doctors' wives are invited to attend. (Auxiliary members will not register for this meeting. Woman's Auxiliary Registration will start Sunday morning in the Main Lobby.)

SUNDAY, APRIL 30

9:00 a.m.—Executive Committee breakfast meeting, Garden Room.

2:30 p.m.—Pre-Convention Board Meeting, Rose Room.

7:00-8:00 p.m.—California Medical Association Reception (admittance by ticket to Presidents' Dinner) honoring Doctor Paul D. Foster, President of the California Medical Association, and Mrs. Samuel Gendel, President of the Woman's Auxiliary to the California Medical Association, Embassy Room.

8:00 p.m.—Presidents' Dinner and Ball honoring the President of the California Medical Association, Dr. Paul D. Foster, and the President of the Woman's Auxiliary to the California Medical Association, Mrs. Samuel Gendel, Cocoanut Grove. Formal dress optional.

MONDAY, MAY 1

9:00 a.m.—First Business Meeting of the 31st Annual Meeting, Mrs. Samuel Gendel, presiding, East Venetian Room.

2:00 p.m.—Second business meeting, East Venetian Room.

TUESDAY, MAY 2

9:00 a.m.—Third Business Meeting, Mrs. Samuel Gendel, presiding, East Venetian Room.

12:45 p.m.—President's Luncheon and Fashion Show honoring Mrs. Lawrence Custer; members of the State Advisory Board, and Past State Presidents, Cocoanut Grove. Style Show by Irene Somerset Fashions. Entertainment: John Raitt, baritone.

3:30 p.m.—Post-Convention Board Meeting. Mrs. Lawrence Custer, presiding, Grove Lounge.

Technical Exhibits

The Ballroom, Sunset Room and Boulevard Room of the Ambassador Hotel will again house the technical exhibits. This area is noted as outstanding for exhibit purposes and a record number of exhibitors will present their products and services for members of the Association.

All exhibits and all products exhibited have been screened by a committee as a means of eliminating those which do not meet high standards. The exhibitors agree to this procedure and agree that by this means each will be in good company.

Here in one area will be found the latest developments in drugs, equipment and services to aid the physician in his professional activities. All physicians are urged to visit the exhibits; meetings have been planned to allow ample time for this important activity. Your visit will not only help bring your own knowledge up to date; it will demonstrate to our exhibitors, who contribute so much to the success of the meeting, that we recognize and appreciate their cooperation.

Exhibits will be open from 9 a.m. to 5 p.m. each day, with an early closing on Wednesday.

ABBOTT LABORATORIES — **Sunset Room**
North Chicago, Illinois — **Booth 72**

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

ALTA-DENA DAIRY — **Sunset Room**
Monrovia — **Booth 36**

Certified Milk will again be displayed along with Los Angeles County Medical Association Milk Commission Laboratory records for your examination.

KEFIR—*The new Continental Cultured Milk Drink* will be served. Kefir contains Lactobacillus Acidophilus and L. Bulgaricus. Kefir leaves an exhilarating after-taste in the mouth, making it pleasant to drink and is a very easy to digest protein food.

Doctors are recommending it for use following antibiotic therapy to help restore bacterial flora in the intestinal tract.

Qualified men will be at your service to answer your questions and serve you samples. Ask for the descriptive card for your file.

AMBCO INC. — **Sunset Room**
Los Angeles — **Booth 73**

AMBCO representatives cordially invite you to visit their booth where they will exhibit the latest developments in Transistorized AUDIOMETERS, including new models—a complete line of audiometers for every use and for every price.

AMBCO line of audiometers include the ever popular, battery-operated instrument, the OTOMETER and OTO-CHEK, as well as A.C.-powered units.

Competent personnel will be on hand to answer any questions you may have concerning our leading products and new developments, in the auditory field.

AMERICAN STERILIZER COMPANY — **Boulevard Room**
Erie, Pennsylvania — **Booth 108**

Visitors to the American Sterilizer exhibits in booth 108 will have the opportunity personally to operate the recently introduced Dynapoise Physician's Table. Physicians in all fields of practice have shown marked interest in the ease and speed of patient positioning attained by Amsco's new concept of a powerized examination and treatment table.

Also on exhibit will be the complete line of sterilizers for offices, clinics, and medical facilities in industry. Included will be the new 8816M Autoclave, the 1022 Cabinet Sterilizer, and the ever-popular 613R Dynaclave. Amsco Sanitizers will also be displayed.

ARMOUR PHARMACEUTICAL COMPANY — **Sunset Room**
Chicago, Illinois — **Booth 68**

The Armour Pharmaceutical Company exhibit will feature Chymoral, a new systemic anti-inflammatory enzyme tablet which reduces inflammation, swelling and pain; Chymar Aqueous, the parenteral systemic anti-inflammatory enzyme; and Pentritol Tempules which release 30 mg. of pentaerythritol tetranitrate in three divided doses to provide twelve-hour relief in angina pectoris.

AUDIO-DIGEST FOUNDATION — **Ballroom**
Glendale — **Booth 14**

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association), gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in six series—General Practice (issued weekly and bi-weekly), and Pediatrics, Internal Medicine, Surgery, Obstetrics and Gynecology, Anesthesiology (all issued semi-monthly). The one-hour long tapes are selected and reviewed by a professional Board of Editors. Digest subscribers listen in their car, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

BARNES-HIND LABORATORIES, INC. — **Sunset Room**
Sunnyvale — **Booth 58**

DON BAXTER, INC. — **Boulevard Room**
Glendale — **Booth 94**

Don Baxter, Inc. presents, "Safety Through Simplicity," the finest parenteral system.

Features will be: The Isolyte Family of electrolyte solutions. Simplified therapy for maintenance and replacement in adults and children.

The Kadalex family of Potassium Chloride Solutions containing 20 and 40 mEq. per liter. Now available in these most used dosages.

Peritoneal Dialysis solutions with complete administration equipment which greatly simplifies this procedure with a high degree of safety.

STYLEX, the finest precision-made, expendable syringe now available in a wide range of sizes and needle combinations.

BERKELEY BIOLOGICALS — Boulevard Room
Berkeley — Booth 102

A complete line of allergenic extracts for diagnostic testing and for specific treatment of allergic diseases will be emphasized. Diagnostic testing sets containing a regional selection of pollens will be on display for inspection. A typical treatment set will also be on display and descriptive literature and pamphlets will be available for the physicians.

Our representatives will be present to illustrate the use of the test sets and to discuss and answer questions on our products and service.

BORCHERDT CO. — Sunset Room
Chicago, Illinois — Booth 47

Borcherdt's are featuring:

MALT SOUP EXTRACT: Laxative modifier of milk for constipated babies. Also useful for geriatric constipation and pruritus ani.

UROLITIA: For chronic urinary tract infections in older patients. Quickly relieves burning urination.

FERROMALT TABLETS: Non-constipating Ferrous Sulfate Tablets. Good clinical response without usual side effects of oral iron. FERROMALT TABLETS are inexpensive and well tolerated.

Stop in for recently published papers and samples.

BROEMMEL PHARMACEUTICALS — Sunset Room
San Francisco — Booth 44

Broemmel Pharmaceuticals specializes in products for eye, ear, nose and throat diseases. High ethical standards, constant efforts toward continuous improvement and keeping abreast with the latest medical developments have contributed to the excellent rating its products enjoy among all those who know them. The more recent Broemmel products which highlight this year's exhibit are: OP-ISOPHRIN-AB, an antibiotic sterile ophthalmic solution without steroids, BRO-PARIN, an optic preparation with the heparin-antibiotic complex, WET TONE-B, a contact lens solution. Since Broemmel products speak for themselves, all members are invited to visit Booth 44 and obtain information, literature and samples.

CHARLES BRUNING COMPANY — Boulevard Room
Mount Prospect, Illinois — Booth 91

The Bruning Company will feature the newest method of processing doctors' monthly statements. It eliminates typing of the patient's name and address and gives each patient an itemized record of charges. Any nurse or office girl can process 500 statements in less than two hours.

BURROUGHS WELLCOME & CO. — Sunset Room
Tuckahoe, New York — Booth 76

BURTON, PARSONS & COMPANY — Sunset Room
Washington, D. C. — Booth 35

You are cordially invited to stop at the Burton, Parsons & Company exhibit where our representative will be showing Konsyl, L. A. Formula, neutraCarb and EKG Sol. Samples, descriptive literature and information will be available on all these products. Konsyl and L. A. Formula are the original refined Psyllium bulk laxatives. neutraCarb is the antacid, with Vitamin C, and has a delightful lemon flavor. EKG Sol is the new and modern electrode cream for electrocardiology and electro-encephalography.

CANRIGHT CORPORATION — Sunset Room
Glendale — Booth 57

G. W. CARNRICK COMPANY — Boulevard Room
Newark, New Jersey — Booth 80

CASS & JOHANSING — Sunset Room
Los Angeles — Booth 48

Representatives will be present to discuss the approved Association Insurance Programs—Professional Liability, Life and Accidental Death and Dismemberment.

In addition, assistance in complete insurance programming will be available.

CIBA PHARMACEUTICAL PRODUCTS INC. — Sunset Room
Summit, New Jersey — Booth 55

THE COCA-COLA COMPANY — Sunset Room
Atlanta, Georgia — Booth 43

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Los Angeles and the Coca-Cola Company.

COLUMBUS PHARMACAL COMPANY
Columbus, Ohio — Boulevard Room—Booth 92

You are cordially invited to visit the COLUMBUS booth. Featured is GERONIAZOL TT (Tempotrol—time controlled therapy)—combats senile confusion around the clock. Continuous cerebral oxygenation with one tablet b.i.d. Decreases anxiety and emotional instability. Improves appetite, sleep pattern and interest of patient. Geroniazol TT is non-hormonal, non-excitatory and non-hypertensive.

CORECO RESEARCH CORP. — Ballroom Foyer
New York, New York — Booth 3

The Coret camera embodies the principle of electronic flash and constant automatic control of such factors as distance, aperture, field and exposure. Now, for the first time, Coreco offers a completely automatic professional clinical camera purposely designed to achieve the ultimate in surface, intraoral, and intra-tubular photography. Because of the simplicity of operation, even an inexperienced doctor or nurse can achieve consistently perfect color transparencies.

CROOKES-BARNES LABORATORIES, INC. — Sunset Room
Wayne, New Jersey — Booth 37

The Crookes-Barnes Laboratories exhibit includes preparations of special interest in the fields of:

Atherosclerosis—LENIC H.P.—Capsules to help lower blood cholesterol levels.

Geriatric Mental Health—L-BLUTAVITE—A safe biochemical cerebral tonic to improve mental status and social adjustment in the elderly patient.

Ophthalmology — ISO-SOL STERILE OPHTHALMICS — For clinical, surgical and out-patient use.

CUTTER LABORATORIES — Sunset Room
Berkeley — Booth 75

Cutter Laboratories exhibit will feature the following products:

Barbicaine, an "infant colic" preparation which is composed of procaine hydrochloride, pentabarbital and phenobarbital in a stabilized solution for drop dosage.

Hyper-Tet, the prophylactic tetanus antitoxin product made from the gamma globulin fraction of human blood from hyper-immunized donors.

Other blood fraction specialties—*Hypertussis, Hyparotin, Polio Immune Globulin.*

By-Na-Mid, a new anti-fungal topical agent in four different forms—ointment, tincture, lotion and powder.

EDWARD DALTON COMPANY — Sunset Room
Evansville, Indiana — Booths 39 and 40

DESITIN CHEMICAL COMPANY — Ballroom
Providence, Rhode Island — Booth 21

DESITIN OINTMENT: For treatment of burns, ulcers, diaper rash, abrasions, etc.

DESITIN POWDER: Relieves chafing, sunburn, diaper rash, etc.

DESITIN SUPPOSITORIES and RECTAL OINTMENT: Relieve pain and itching in uncomplicated hemorrhoids, fissures.

DESITIN BABY LOTION: Protective, antiseptic.

DESITIN ACNE CREAM: A non-staining, flesh-tinted "Medicream" for the treatment of Acne Vulgaris.

DESITIN COSMETIC AND NURSERY SOAP: Supermild.

DESITIN SUPPOSITORIES with HYDROCORTISONE: Prompt response to inflammatory conditions in proctitis, severe pruritus, edema.

DEVEREUX SCHOOLS, INC. — Boulevard Room
Booth 77

THE DIETENE COMPANY — Sunset Room
Minneapolis, Minnesota — Booth 49

Have you tasted Meritene? Meritene is the good-tasting *Protein*-vitamin-mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment.

While there, review also our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.

Meritene and Dietene are advertised only to the Medical Profession.

DOHO CHEMICAL CORP. — Ballroom
New York, New York — Booth 13

AURALGAN: Ear medication for relief of pain in Otitis Media; also removal of Cerumen;

RHINALGAN: Nasal decongestant free from systemic or circulatory effect. Safe for infants—aged.

OTOSMOSAN: Non-Toxic fungicide-bactericide (gram negative-gram positive) for suppurative and aural dermatomycotic ears;

LARYLGAN: Soothing throat spray and gargle for infectious and noninfectious sore throat involvements.

BIOTOSMOSAN HC: The solution to the "Problem Ear." Antimicrobial, Anti-inflammatory, De-inflammatory, Antiallergic, Antipruritic.

DORSEY LABORATORIES — Sunset Room
Lincoln, Nebraska — Booth 45

EATON LABORATORIES — Ballroom
Norwich, New York — Booth 20

NEW FURADANTIN (brand of nitrofurantoin) SODIUM FOR INTRAVENOUS USE—an alternative route of administration for Furadantin in patients unable to take oral medication.

FURADANTIN SODIUM for Intravenous Use fills a need for a parenteral form in the treatment of genitourinary infections, such as pyelonephritis, pyelitis, cystitis, prostatitis —and in selected systemic infections—even some which have failed to respond to other antibacterial therapy.

EISELE & COMPANY — Sunset Room
Nashville, Tennessee — Booth 62

ELECTRONIC INDUSTRIES, INC. — Sunset Room
Berkeley — Booth 41

ENCYCLOPAEDIA BRITANNICA — Sunset Room
Chicago, Illinois — Booth 42

Encyclopaedia Britannica, Inc.—latest revision in 200 years —available in Imperial or Heirloom bindings at discount prices.

CHARLES O. FINLEY & CO. — Sunset Room
Chicago, Illinois — Booth 31

E. FOUGERA & CO. — Sunset Room
Hicksville, New York — Booth 63

The Fougera exhibit will feature older, well established products and newer items of interest to all physicians, but particularly applicable to Radiology, Cardiology, Internal Medicine, Dermatology. Clinical material, literature and office aids in connection with these areas of medicine are available at the booth. Informed attendants will be pleased to service your request.

GEIGY PHARMACEUTICALS — Ballroom
Yonkers, New York — Booths 23 and 24

Geigy cordially invites Members and Guests of the Association to its display booths. The newest technics relating to bowel hygiene in addition to more recent developments in therapy of cardiovascular, metabolic and psychiatric disorders may be discussed with physicians and representatives in attendance.

GREAT BOOKS OF THE WESTERN WORLD — Ballroom Foyer
Chicago, Illinois — Booth 4

GREAT BOOKS and The SYNTOPICON presented by Encyclopaedia Britannica in collaboration with the University of Chicago. The accumulated wisdom of three thousand years of civilization, together with the revolutionary idea-index called the SYNTOPICON—that ingenious new literary invention making magically available and easily accessible all of the wisdom and the knowledge contained in the Great Books. These books contain the works that are indispensable to the liberal education of a free man in the 20th century. They are the books that are essential in the library of every thinking person.

H. J. HEINZ COMPANY — Sunset Room
Pittsburgh, Pennsylvania — Booth 34

Heinz Baby Foods announces new varieties—Strained and Junior Cottage Cheese and Bananas; Strained and Junior Pineapple-Orange Dessert; Strained and Junior High Meat Dinners; Ham and Eggs (yolks) in Strained; several New Juice Drinks: Orange-Pineapple, Orange-Apple-Banana, Pineapple-Grapefruit—all with Vitamin C added.

Heinz Baby Foods are packed in screw cap jars in every variety in glass.

Literature includes Nutritional Data, "ABC's for Baby's Mealtime," and up-to-date lists of Heinz Baby Foods including a list of those that are free of wheat, egg, milk and citrus juices. Please register for these.

HOLLAND-RANTOS COMPANY, INC. — Ballroom
New York, New York — Booth 97

The H-R exhibit will feature:

. . . Antimycotic (non-messy) HYVA *Gentian Violet Vaginal Tablets;*

. . . Trichomonicidal/fungicidal/bactericidal NYLMERATE *Jelly and Antiseptic Solution Concentrate* for vaginal trichomoniasis and mixed infections;

. . . HOLLANDEX *Silicone Ointment with Natural Vitamins A and D*—medication for neuro- and contact dermatitis, decubitus ulcers, diaper rash, skin dryness/chafing, etc.;

. . . *Special* KOROMEX *A* for use when "jelly-alone" for conception control is advised, also contouring KORO-FLEX *Diaphragms* (facilitate correct placement), and standard KOROMEX *Jelly, Cream, Diaphragms and Sets.*

JESSUP CERTIFIED FARMS — Sunset Room
Glendale — Booth 46

Educational in nature, the Jessup exhibit points up to the functions performed by the American Association of Medical Milk Commissions at the national level, and the work of the Los Angeles County Medical Milk Commission at the local level.

Free samples of Certified Guernsey, Certified Holstein, and Certified Non-Fat Milk are available at the Dairy Bar.

JOHNSON & JOHNSON — Boulevard Room
New Brunswick, New Jersey — Booth 101

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is SURGICEL Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. DERMICEL Surgical Tape, a special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is also of particular interest. Other products, designed for your office, hospital or patient use, are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

KEY CORPORATION PHARMACEUTICALS — Boulevard Room
Miami, Florida — Booth 81

LEDERLE LABORATORIES — Ballroom
Pearl River, New York — Booth 6

Your Lederle representative will be on hand to serve you. He can furnish information on any Lederle product and is prepared to bring to bear on any of your medical problems the knowledge of the world-wide Lederle research organization.

ELI LILLY AND COMPANY — Boulevard Room
Indianapolis, Indiana — Booths 95 and 96

You are cordially invited to visit the Lilly exhibit located in booths 95 and 96. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

J. B. LIPPINCOTT COMPANY — Ballroom Foyer
Philadelphia, Pennsylvania — Booth 1

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

LLOYD BROTHERS, Inc. — Boulevard Room
Cincinnati, Ohio — Booth 110

Welcome to the Lloyd Brothers exhibit. Our professionally trained sales representatives will be pleased to greet you and discuss the merits of our products in your practice. Of particular interest will be a new booklet on erythropoietin, the erythropoietic hormone.

LOMA LINDA FOOD COMPANY — Sunset Room
Arlington — Booth 61

With the background of years of experience in perfecting a hypoallergenic milk powder, and also a newly developed concentrated liquid milk the protein of which is fully derived from the soybean and formulated with other essential additives to care for the needs of babies, growing children and adults, the Loma Linda Food Company will be happy to welcome you to their exhibit. Attendants will be pleased to discuss the values of Soyalac powder and concentrated liquid. Samples of this flavorful product will be served at the exhibit.

P. LORILLARD COMPANY — Sunset Room
New York, New York — Booth 66

P. Lorillard Company invites you to visit the KENT Cigarette Exhibit.

We are presenting the Story of Kent Cigarettes. And a big part of that story is why you'll feel better about smoking with the taste of Kent.

Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.

A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the convention.

MALTBIE LABORATORIES — Sunset Room
Belleville, New Jersey — Booth 67

MARION LABORATORIES, INC. — Sunset Room
Kansas City, Missouri — Booth 64

MARSHALL ERDMAN & ASSOCIATES, INC. — Boulevard Room
Santa Barbara — Booth 105

Pictures and typical floor plans of Marshall Erdman pre-cut and pre-fabricated custom-designed medical office buildings for doctors in solo or group practice. Marshall

Erdman & Associates, Inc., specialists with over 100 years experience in designing, engineering and building quality medical office buildings for doctors in over 25 states. A complete building service.

THE S. E. MASSENGILL COMPANY — **Boulevard Room**
Bristol, Tennessee — **Booth 104**

The Massengill exhibit will feature TRIMAGILL POWDER and TRIMAGILL VAGINAL INSERTS—now THE LOGICAL THERAPY FOR VAGINAL INFECTIONS! Trimagill is a new, rational, convenient therapy for vaginal infections; Adrenosem, the unique systemic hemostat; Obedrin, the superior weight reducing aid; the Salcort Family, offering a complete range of arthritic therapy; and Massengill Powder, the douche preparation of choice. If you wish, literature and samples will be available by mail to you. Best wishes from Massengill Representatives to the members of the California Medical Association for a most informative meeting.

McNEIL LABORATORIES — **Ballroom Foyer**
Philadelphia, Pennsylvania — **Booth 2**

MEAD JOHNSON & COMPANY — **Sunset Room**
Evansville, Indiana — **Booth 53**

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

MEDICAL INDUSTRIES — **Boulevard Room**
Chatsworth — **Booth 84**

THE MEDICAL PROTECTIVE COMPANY — **Ballroom**
Fort Wayne, Indiana — **Booth 15**

As the No. 1 Malpractice Insurer, The Medical Protective Company offers unexcelled coverage. With exceptional proficiency in defense, so essential to the Doctor's protection today, its experience in successfully handling 81,000 claims and suits during sixty-two years of Professional Protection Exclusively is unparalleled in the professional liability field.

MERCK SHARP & DOHME — **Ballroom**
Philadelphia, Pennsylvania — **Booth 19**

WM. S. MERRELL COMPANY — **Sunset Room**
Cincinnati, Ohio — **Booth 33**

A summary of mounting clinical evidence attesting to the effectiveness of MER/29 in patients with hyper-cholesterolemia and related conditions will be presented by MERRELL. Update your knowledge of MER/29 by stopping briefly at the MERRELL display. Salesmen will summarize the extensive results of MER/29 therapy for you and answer questions you may have. Best wishes for a most enjoyable convention.

MILEX-FERTILEX COMPANY — **Sunset Room**
Los Angeles — **Booth 69**

New Cervical Spatula described as "best designed instrument for taking Papanicolaou smears" now included with Cancer Detection Sets.

New design WIDE SEAL CRESCENT (suction) diaphragm on display.

MISSION PHARMACAL COMPANY — **Boulevard Room**
San Antonio, Texas — **Booth 100**

Mission will present the following products: Homapin-4, a potent antispasmodic which is reported to be four times as potent as atropine in depressing ganglionic transmission; Prulet Tablets, a gentle laxative, containing an active ingredient which is analogous to a substance found in prunes; Supac-B, analgesic tablet, is a superior buffered A.P.C.

MUTUAL BENEFIT LIFE INSURANCE COMPANY — **Boulevard Room**
Newark, New Jersey — **Booth 109**

"Financial Planning for the Physician." Trained representatives associated with the Los Angeles, San Diego, San Francisco and San Jose offices give information at the booth on estate planning, NSLI disability protection, and other aspects of life insurance. Visitors can secure Tax Calculator Slide Rule at booth without obligation, can register for "Estate Planning For Physicians" and other booklets that the physician will find helpful in financial planning. Mutual Benefit Life was founded in 1845 and has had its home office in Newark, N. J. since its founding. The company appointed its first representative in California in 1849.

THE NETTLESHIP COMPANY — **Sunset Room**
Los Angeles — **Booth 70**

Administrators of Professional Liability, Group Accident and Sickness, and Life Insurance Programs for County Medical Associations in Southern California.

Qualified representatives available to discuss problems pertaining to hospital or individual professional liability coverage, accident and sickness, life, or other types of insurance.

Literature, which will assist in the prevention of claims and various forms to be used to protect, as far as possible, against malpractice claims.

ORGANON, INC. — **Sunset Room**
West Orange, New Jersey — **Booth 50**

Physicians are cordially invited to visit the Organon booth for information on useful therapeutic specialties. Included among these will be: CORTROPHIN-ZINC, the long-acting aqueous ACTH indicated for the relief of allergic and inflammatory disorders; DURABOLIN, a totally new anabolic stimulant offering prolonged tissue-building action; NUGESTORAL, the new aid for the abortion-prone patient containing those factors known to contribute to fetal salvage and WIGRAINE, the rapid acting, complete migraine therapy. Organon representatives will gladly discuss these specialties with all interested physicians.

ORTHO PHARMACEUTICAL CORPORATION — **Boulevard Room**
Raritan, New Jersey — **Booth 78**

At booth No. 78 ORTHO is presenting the new monilicidal vaginal cream, SPOROSTACIN. This emollient white cream contains the unique chemical chlordantoin which, because of its structure, has the unusual ability to penetrate the monilial membrane. Clinically proved, SPOROSTACIN Chlordantoin Cream is the treatment of choice in monilial vaginitis.

PACIFIC TELEPHONE COMPANY — **Ballroom—Booth 9**

PARKE, DAVIS & COMPANY — Ballroom
Detroit, Michigan — Booth 30

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

PERSON & COVEY — Sunset Room
Glendale — Booth 51

PHARMACIA LABORATORIES, INC. — Boulevard Room
New York, New York — Booth 99

Pharmacia Laboratories, Inc., 501 5th Avenue, New York, New York, will exhibit in booth No. 99, its product, AZULFIDINE, a new sulfa compound for the treatment of ulcerative colitis and regional enteritis. Also, Pharmacia will exhibit PHARMALAX, "the suppository with enema-like action." The quick action of Pharmalax causes defecation through mechanical stimulation of the intestinal musculature by carbon-dioxide released from the suppository. SKOPYL, a new concept in the medical treatment of infant colic will also be displayed. Literature and important reprints will be available upon request.

PITCHER ELECTRONICS, INC. — Ballroom
Brea — Booth 18

The latest modality available to the medical profession will be featured. Be sure to see the unit that provides therapeutic cold in a convenient unit for office use. Factory trained personnel in attendance at the booth.

Also to be shown is the latest in cleaning surgical instruments, syringes and needles—STEAM IMPLOSION, combined with ultrasound.

PROCTER & GAMBLE COMPANY — Sunset Room
Cincinnati, Ohio — Booth 71

Ivory Soap (Procter & Gamble) offers a series of time-saving leaflet pads for doctors, each pad containing fifty identical tear-out sheets. These sheets, which may be given to patients, contain routine instructions covering six different topics. There are also samples of other free, helpful material prepared especially for physicians.

Mrs. Christyne Schwab in charge.

THE PURDUE FREDERICK COMPANY — Sunset Room
New York, New York — Booth 32

Cerumenex: A cerumenolytic for the easy and quick removal of excessive cerumen. Non-irritating and non-sensitizing. Contains Cerapon, a new surfactant, with propylene glycol as carrier and chlorbutanol as preservative.

Senokot: Constipation corrective. Concentrated total senna glycosides which activate Auerbach's plexus, initiate normal neuroperistalsis.

Senokap: Produces timed stool softening and elimination by the addition of dioctyl sodium sulfosuccinate to Senokot.

Senokot with Psyllium: Adds the bulk effect of psyllium to Senokot.

Senobile: Utilizes the peristaltic action of bile salts with Senokot.

R. J. REYNOLDS TOBACCO COMPANY — Boulevard Room
Winston-Salem, North Carolina — Booth 87

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol fresh SALEM, or CAVALIER King Size Cigarettes.

RITTER COMPANY, INC. — Sunset Room
Rochester, New York — Booth 38

The Ritter Medical Division will exhibit the automatic, self-calculating L-F BasalMeteR, the Ritter Universal Table with exclusive hydraulic lift and the Castle Office Sterilizers and Examining Lights.

Capable factory trained representatives will be on hand to demonstrate these products and answer your questions.

It will be a pleasure to have you visit our exhibit.

A. H. ROBINS COMPANY, INC. — Ballroom
Richmond, Virginia — Booth 22

Ask the Robins representatives about DIMETANE, the antihistamine with unsurpassed potency and placebo-like side effects, and ENTOZYME and DONNAZYME, the digestants proved especially suitable for your gallbladder or "nervous indigestion" patients, respectively. They will also be happy to discuss time-tested DONNATAL (antispasmodic-sedative) and ALLBEE WITH C (high potency B and C vitamins) or other Robins products.

ROCHE LABORATORIES — Ballroom
Nutley, New Jersey — Booth 16

Librium—a therapeutic agent for superior, safer, faster control of anxiety, nervousness, tension and other common emotional disturbances without the dulling effect of depressant action of the tranquilizers.

Madribon—is a completely different, low-dosage sulfonamide of particular value in the treatment of bacterial infections especially respiratory infections.

Tigan—a specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting.

J. B. ROERIG & CO. — Ballroom
New York, New York — Booth 26

ROSS LABORATORIES — Sunset Room
Columbus, Ohio — Booth 74

Ross Laboratories, who also manufactures Similac, features SIMILAC WITH IRON, a new prepared infant formula supplying 12 mg. of ferrous iron per quart of formula. SIMILAC WITH IRON is designed for use at the time exogenous iron is indicated in infancy to support the usual diet and to provide prophylaxis against iron deficiency during the period of greatest incidence, from 6 to 18 months of life. Some special indications for use are following placental or traumatic blood loss, for prematures and twins, for the pallid, irritable, anorectic infant with an unsatisfactory blood picture and following prolonged infection or diarrhea.

SANBORN COMPANY — Ballroom
Waltham, Massachusetts — Booth 12

Exhibiting the latest in Sanborn precision Electrocardiographs. The Sanborn Viso Cardiette 100 and 100M, Sanborn Visette 300 18 pounds portable, Sanborn Twin Beam 62 Phonocardiograph and the Rappaport-Sprague Acoustic Stethoscope.

SANDOZ PHARMACEUTICALS — Ballroom
Hanover, New Jersey — Booth 29

Sandoz Pharmaceuticals cordially invites you to visit our display at booth No. 29.

MELLARIL the first selective phenotiazine exhibiting potent tranquilizing activity without anti-emetic action. The greater toleration, notably relative absence of extra pyramidal symptoms, enhances its usefulness in management of major and minor emotional disorders.

PLEXONAL preferred daytime sedative-relaxant.

SYNTOCINON—Nasal Spray—New—Syntocinon Nasal Spray for intranasal application of synthetic oxytocin (Syntocinon). Activates the milk-ejection reflex to stimulate milk let-down. Overcomes some of the complications associated with lactation, e.g., engorged, painful, tender or distended breasts due to milk retention and stasis or the circumscribed, painful induration of incipient mastitis. Accelerates involution of the uterus.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

W. B. SAUNDERS COMPANY — **Sunset Room**
Philadelphia, Pennsylvania — **Booth 52**

New Saunders books published this year include clinical volumes: Edwards: An Atlas of Acquired Diseases of the Heart; Beckman: Pharmacology; Huffman: Gynecology and Obstetrics; Pillsbury: Cutaneous Medicine; Nagan: A Medical Almanac; and the new Current Therapy 1961.

SCHERING CORPORATION — **Sunset Room**
Bloomfield, New Jersey — **Booth 56**

Schering Corporation welcomes the members of the California Medical Association. Our representatives cordially invite you to visit the Schering technical exhibit where they will be glad to discuss with you the recent therapeutic advances in Schering research. Products featured will be: Rela, a new muscle relaxant-analgesic that eases sprains, strains and low back pains; Naqua, effective new oral diuretic—and anti-hypertensive; Alpen, the new synthesized oral penicillin; and Fulvicin, the first oral antifungal antibiotic for ringworm.

SCHIEFFELIN & CO. — **Sunset Room**
New York, New York — **Booth 65**

SCHIEFFELIN & Co. is exhibiting several products of importance and interest. Neo-Resulin-F offers four pronged action for acne therapy; Hydro-Tar affords the patient a therapeutic combination of crude coal tar and hydrocortisone.

Also of interest to the attending physician is Estivin. Estivin is the ophthalmic preparation suggested for hay fever and other minor ocular irritations.

In addition, C.R.P.A. (C-Reactive Protein Antiserum, Schieffelin) will be demonstrated. C.R.P.A. offers the physician an easy diagnosis for hidden inflammation. Hemoccult, the new standard for detection of occult blood, will also be demonstrated.

Professional representatives for Schieffelin & Co. will be at your service to discuss the above mentioned products, as well as other products under clinical evaluation and research.

JULIUS SCHMID, INC. — **Sunset Room**
New York, New York — **Booth 59**

An interesting and informative exhibit featuring IMMOLIN Vaginal Cream-Jel for use without a diaphragm; RAMSES Flexible Cushioned and BENDEX Diaphragms; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES, SHEIK and ESQUIRE Rubber Condoms for the control of trichomonal reinfection.

G. D. SEARLE & CO. — **Ballroom**
Chicago, Illinois — **Booth 25**

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be our products Aldactone, Enovid, and Nilevar.

SHELLEY PROFESSIONAL PRODUCTS, INC. — **Boulevard Room**
Los Angeles — **Booth 86**

SHERMAN LABORATORIES — **Boulevard Room**
Detroit, Michigan — **Booth 111**

Severe asthmatic attacks are not merely relieved, but *terminated* in 10 to 20 minutes by Elixophyllin, given orally. In milder attacks, its speed has been described as "instantaneous."

Wheezing, retrosternal congestion and coughing caused by bronchospasm are usually relieved in 15 minutes following a dose of 45 cc. of Elixophyllin.

Vital capacity increases were noted as soon as 5 minutes after administration. Pick up these data and reports on their clinical significance at the Sherman booth.

SMITH KLINE & FRENCH LABORATORIES — **Ballroom**
Philadelphia, Pennsylvania — **Booth 28**

SK&F features (1) new 'Coplexen' Liquid, for symptomatic control of the cold complex in children; (2) Ornade Spansule capsules, the unique oral nasal decongestant for symptomatic treatment of upper respiratory distress; (3) Eskatrol Spansule capsules, for daylong control of appetite and relief of the psychic stress that causes overeating; (4) Stelazine 2 mg. Tablets, a specific antianxiety agent that helps restore emotional stability without soporific effect; and (5) Combid Spansule capsules, for comprehensive control—psychic as well as physical—of the patient with ulcer, g.i. spasm and other gastrointestinal disorders. Our representatives welcome the opportunity to discuss these and other SK&F products with you.

SMITH, MILLER & PATCH, INC. — **Ballroom**
New York, New York — **Booth 8**

SMITH, MILLER & PATCH, INC., N. Y., N. Y.—Features TRULASE . . . the only chewable digestive aid designed to PREVENT pain and discomfort of gas and distention due to indigestion. Acts physiologically without delay. Contains three essential enzymes, standardized to assure dependable activity.

VITRON-C . . . a new oral hematinic, ferrous fumarate with ascorbic acid. Vitron-C has been clinically proven to be effective in treating iron deficiency anemia in patients with gastrointestinal irritability, or ulcerative disease. A chewable pleasantly flavored sugar-free tablet that offers iron with maximum toleration.

BISTRIMATE—A safe, effective and economical therapeutic to combat subacute, chronic or recurrent sore throats. Preliminary tissue studies indicate Bistrimate has an antiviral effect on Adenovirus type 3 and Adenovirus type 7.

E. R. SQUIBB & SONS — **Ballroom**
New York, New York — **Booth 10**

J. W. STACEY, INC. — Ballroom Foyer
Palo Alto — Booth 7

Stacey's, established for over 35 years, provides the doctor in the West with a source of supply of all medical books. At booth No. 7 you will find on display the latest books in medicine, surgery, and the specialties. You are invited to browse at your leisure.

THE STUART COMPANY — Ballroom
Pasadena — Booth 17

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products developed in our new and modern laboratories which have received international acclaim.

SWIFT & COMPANY — Boulevard Room
Chicago, Illinois — Booth 89

A complete line of Swift's all-meat varieties—the economical forms of meat protein for infant feeding—plus egg yolk products and high Meat Dinners—for your infant patients, are exhibited at the Swift Booth. We invite your questions regarding the results of clinical studies, sponsored by Swift, investigating the role of meat in the infant diet. Reprints of these studies are available. You may also obtain copies of our attractively illustrated booklet for distribution to mothers.

TESTAGAR & CO., INC. — Boulevard Room
Detroit, Michigan — Booth 83

The professional service representatives of Testagar & Co., Inc. will be happy to pass on the latest information on the use of Heparin Sodium (Hepathrom) as an office procedure in the treatment of acute and chronic atherosclerotic conditions; as a treatment for peripheral artery diseases. Information is also available on the use of Heparin (Hepathrom) as a prophylactic in coronary artery diseases. Information, samples and literature will also be available on Felsules (Chloral Hydrate-Fellows). The latest literature stresses the value of chloral hydrate in the geriatric patient.

TRU-EZE MFG. CO., INC. — Ballroom Foyer
Burbank — Booth 5

Demonstrating the "TRACTOMATIC" portable intermittent traction machine. Adaptable to vertical cervical traction or horizontal cervical and lumbar traction.

Also showing the NEW "TRU-TRAC" RT-99 Traction and Therapy Table. Split in two sections: lumbar section operates on ball-bearing rollers, cervical traction at any angle up to 45 degrees.

For the profession with limited office space see the "TRU-TRAC" Flexion Traction Chair. Traction at any angle up to 45 degrees providing definite *Flexion.*

Improved traction sets for home use, supplementing office treatment and aiding in earlier hospital release.

U. S. VITAMIN & PHARMACEUTICAL CORPORATION — Boulevard Room
New York, New York — Booth 113

DBI—new "full-range" oral hypoglycemic agent. DBI, brand of phenformin (N^1-B-phenethylbiguanide HCl) is distinctly different in chemical structure and physiological action from the oral hypoglycemic sulfonylureas. It effectively lowers blood sugar and eliminates glycosuria in mild, moderate and severe diabetes. DBI, in combination with insulin, improves regulation of "brittle" adult and juvenile diabetes. In juvenile diabetes, DBI often permits up to 50 per cent reduction in insulin requirement. Also effective in the insulin-resistant, and in primary and secondary tolbutamide and chlorpropamide failures. Full details available.

THE UPJOHN COMPANY — Boulevard Room
Kalamazoo, Michigan — Booth 98

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

WALKER LABORATORIES — Boulevard Room
Mount Vernon, New York — Booth 112

WALLACE LABORATORIES — Ballroom
Cranbury, New Jersey — Booth 11

WAMPOLE LABORATORIES — Sunset Room
Stamford, Connecticut — Booth 60

HYPTRAN, the new, dual release hypnotic-tranquilizer designed to insure a full night's restful sleep without loss of mental acuity the following morning.

ORGANIDIN, the unique organically bound iodine useful as a mucolytic and expectorant without the side effects normally seen in conjunction with iodide therapy. In addition to Organidin Solution and Tablets, samples and literature will be available on ORGANIDIN ELIXIR, the new dosage form of ORGANIDIN.

RECTALAD ENEMA, the unique truly miniature enema useful in triggering the defecatory reflex to stimulate prompt emptying of the lower bowel. Useful pre- and postoperative, pre- and postdelivery and in the solution of problems associated with occasional constipation.

VoSoL OTIC SOLUTION, for the treatment and prevention of Otitis Externa. VoSoL Otic Solution is virtually 100 per cent effective against all organisms commonly encountered in Otitis Externa. VoSoL is both bactericidal and fungicidal yet contains no antibiotics or sulfonamides.

WARNER-CHILCOTT LABORATORIES, INC. — Boulevard Room
Morris Plains, New Jersey — Booth 93

Gelusil—the physician's antacid—for the relief of gastric hyperacidity and management of peptic ulcer. Provides two protective coating gels for prompt, prolonged relief of pain. Gelusil is all antacid in Action—is non-constipating, contains no laxative.

Peritrate—A long-acting coronary vasodilator for patients with coronary artery disease—whether angina pectoris or coronary occlusion. Peritrate improves coronary blood flow, thereby increasing collateral circulation, with no significant change in blood pressure or pulse rate. Smooth onset of action virtually eliminates nitrate headache.

THE WARREN-TEED PRODUCTS CO. — Boulevard Room
Columbus, Ohio — Booth 79

The Warren-Teed Products Company will feature four pharmaceutical specialties at their exhibit booth.

ILOPAN-CHOLINE TABLETS—Oral therapy for relief and treatment of gastrointestinal gas retention in ambulatory patients.

ILOPAN—An injectable d-pantothenyl alcohol for the treatment and prevention of postoperative gastrointestinal distention.

MODANE—A deconstipant for relief and rehabilitation of the atonic bowel.

KAON—An extremely palatable and well-tolerated oral potassium.

Warren-Teed representatives cordially welcome all registrants to visit their display.

WESTERN SURGICAL SUPPLY CO. — Boulevard Room
Los Angeles — Booth 103

This exhibit will consist of the latest innovations in medical care. Both equipment and new disposable products which will increase the efficiency of the medical field will be shown.

WESTWOOD PHARMACEUTICALS — Boulevard Room
Buffalo, New York — Booth 88

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream, Fostex Cake, Lowila Cake, Lowila Emollient, Sebulex, Fostril, Alpha-Keri.

These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

WHITE LABORATORIES — Ballroom
Kenilworth, New Jersey — Booth 27

WINTHROP LABORATORIES — Sunset Room
New York, New York — Booth 54

ALVODINE, new potent narcotic analgesic that relieves pain without causing drowsiness or hypnosis (in over 90 per cent of patients). Especially well suited for postoperative use, for pain from cancer, angina, cholecystitis, pleurisy, myocardial infarcting; also for preoperative preparation and as a supplement to anesthesia. Alvodine is highly effective orally as well as parenterally. Alvodine is available in scored tablets of 50 mg. and ampuls of 20 mg. (1 cc.), subject to Federal Narcotic Law.

WOODSIDE ACRES — Boulevard Room
Redwood City — Booth 82

Woodside Acres Hospital, exclusively for the treatment of alcoholism. Conditioned Response Therapy method based on the theory that alcoholism is predominantly a physiological demand for alcohol.

WYNN PHARMACAL CORPORATION — Boulevard Room
Philadelphia, Pennsylvania — Booth 90

Information, samples and reprints will be available on QUINAGLUTE DURA-TAB S.M., the only oral Sustained Medication Quinidine Gluconate. Studies show that q. 12 h. dosage maintains effective quinidine blood levels all day and all night—so no night dosage is needed. Quinidine gluconate is well tolerated by the g.i. tract compared to the sulfate because it is ten times as soluble. With Quinaglute Dura-Tab S.M. valleys in plasma blood levels where arrhythmias tend to recur are virtually eliminated. Indicated in atrial fibrillation, flutter, premature contractions, auricular tachycardia, etc.

Also available will be information and samples of AMINOPHYLLINE DURA-TAB S.M., Wynn's exclusive brand of sustained medication aminophylline tablets.

EMERGENCY CALLS AND MESSAGES

Convention Emergency Call Number: DUnkirk 1-2191—8:30 a.m. to 5:00 p.m.

(*Provided through the courtesy of the* PACIFIC TELEPHONE AND TELEGRAPH COMPANY)

Each physician should notify his own secretary regarding the *exact* section he plans to attend and the time of his attendance, and the *convention telephone number*. It is up to the individual physician to keep his own office staff so informed. The Association will *attempt* to transmit messages to the individual physician.

In case of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, HUbbard 3-1581.

CALIFORNIA
MEDICAL
ASSOCIATION

Annual Reports

OFFICERS, COMMISSIONS AND COMMITTEES

for

YEAR 1960

INDEX

OFFICERS AND DELEGATES

General Officers

Paul D. Foster, Los Angeles.....President
Warren L. Bostick, San Rafael.....President-Elect
James C. Doyle, Beverly Hills.....Speaker of House of Delegates
Ivan C. Heron, San Francisco.....Vice-Speaker of House of Delegates
Samuel R. Sherman, San Francisco.....Chairman of Council
Matthew N. Hosmer, San Francisco.....Secretary
Dwight L. Wilbur, San Francisco.....Editor
John Hunton.....Executive Secretary
Howard Hassard.....Executive Director
Peart, Baraty & Hassard.....Legal Counsel

House of Delegates

TOTAL DELEGATES (405)

DELEGATES EX-OFFICIO (42)

Paul D. Foster, Los Angeles.....President
Warren L. Bostick, San Rafael.....President-Elect
James C. Doyle, Beverly Hills.....Speaker of House of Delegates
Ivan C. Heron, San Francisco.....Vice-Speaker of House of Delegates
Samuel R. Sherman, San Francisco.....Chairman of Council
Matthew N. Hosmer, San Francisco.....Secretary
Dwight L. Wilbur, San Francisco.....Editor

COUNCILORS

James C. MacLaggan (1961).....First District
Omer W. Wheeler (1961).....Second District
Malcolm C. Todd (1962).....Office No. 1, Third District
William F. Quinn (1963).....Office No. 2, Third District
J. Norman O'Neill (1961).....Office No. 3, Third District
Arthur A. Kirchner (1962).....Office No. 4, Third District
Joseph P. O'Connor (1963).....Office No. 5, Third District
Gerald W. Shaw (1961).....Office No. 6, Third District
Wilbur G. Rogers (1962).....Office No. 7, Third District
James W. Dalton (1961).....Fourth District
John F. Murray (1963).....Fifth District
Burt L. Davis (1961).....Office No. 1, Sixth District
Albert G. Miller (1962).....Office No. 2, Sixth District
Samuel R. Sherman (1963).....Office No. 1, Seventh District
Donald M. Campbell (1961).....Office No. 2, Seventh District
John G. Morrison (1963).....Eighth District
Carl E. Anderson (1961).....Ninth District
Ralph C. Teall (1962).....Tenth District

ELECTED DELEGATES (358)

Delegates	*Alternates*
Alameda-Contra Costa County (30)	
Anderson, Charles	Adams, Robert
Attwood, C. J.	Baker, Edward
Bagley, Richard	Black, Daniel
Bassett, J. Brandon	Bogart, William
Bell, Dudley P.	Boulware, John
Benson, K. W.	Brock, Kurt
Cronenwett, Paul	Brown, Lawrence E.
Dimmler, Charles	Cannon, Lawrence
Dodds, Donald	Charvet, Leonard
Dozier, Thomas J.	Cobb, B. Otis
Dugan, David	Cope, J. Hallam
Ellis, Grant	Harms, Herbert E.
Etheredge, Samuel	Hart, Charles
Fraser, L. H.	Holden, Herbert
Gadwood, Bernard B.	Hoskins, H. Dean
Gersten, Samuel	Johnston, Ian
Hart, Melvin	Keig, William C.
Harvey, Harold	Kerns, Claude
Henderson, Ernest	Lamb, Gordon
Hudson, Charles	Mutch, William
Johnson, Richard	Page, William
Kay, Harold	Powell, Oscar
Kirk, Ralph	Rihn, Richard
Leet, Robert S.	Ross, Joseph
Maloney, Harold P.	Simon, Daniel
Peterson, H. Harvey	Smith, C. Reed
Richards, Dexter, Jr.	Taines, Robert
Royce, Byron	Twiss, Arthur
Truman, Stanley R.	Weeden, William
Tucker, Dan	Whiting, E. Gale
Butte-Glenn County (2)	
Elmendorf, Thomas	Chiapella, Karl J.
Lawrence, W. Sherwood	Murphy, Franklin L.
Fresno County (6)	
Argo, W. L.	Gray, Clell C., Jr.
Fulmer, Harlan	Hollingsworth, J. B.
Hongola, R. I.	Ludwig, Charles
Howard, Arthur F.	Polhemus, J. A.
Kass, Robert	Snyder, L. J.
Smith, Robb	Steinbach, Owen
Humboldt-Del Norte County (2)	
Eley, James S.	Henderson, Justus
Olson, Fred A.	Loring, Theodore
Imperial County (2)	
Irwin, Willis	Jaquith, George
Schoensee, Burke E.	Wallace, Alejandro
Inyo-Mono County (2)	
Curtis, C. C.	Denton, Robert W.
Scott, C. L.	Zimmerly, Winfred
Kern County (5)	
Day, Robert L.	Cunningham, Ralph
Forney, Robert L.	Ellis, John F.
Patrick, Robert A.	Osell, Levin N.
Strongin, Seymour	Reese, Thomas V.
Vaughan, J. E.	Seibly, J. S.
Kings County (2)	
Chamlee, William F.	Barreiro, A. L.
Christensen, L. F.	Smith, James A.
Lassen-Plumas-Modoc County (2)	
Bross, Willard S., Jr.	Batson, Wilbur C.
Burnett, C. I.	Quinn, William J.

Delegates	*Alternates*
Los Angeles County (141)	
Abbey, John D.	Allen, Browning E., Jr.
Albaugh, Clarence H.	Alter, Marvin S.
Alesen, Lewis A.	Anderson, John R.
Andrews, Herbert J.	Anderson, William R.
Asher, Leonard M.	Andler, Maxwell M.
Baers, Harry A.	Arcadi, John A.
Bailey, Wilbur	Attyah, Albert M.
Baker, Francis J.	Barber, Clifford A.
Barker, Donald E.	Beckner, George L.
Barnes, Roger W.	Bishop, Edwin T.
Barry, Donald J.	Blong, Peter H.
Barton, Jackson A.	Bodensteiner, Cletus H.
Bateman, J. Gordon	Bodner, Henry
Beasom, Ralph D.	Bourne, John L., Jr.
Beatty, Geneva	Boyd, Harold
Beebe, Edson D.	Boyle, Joseph F.
Bennett, Ralph L.	Brayton, Donald F.
Bills, Jack W.	Brennan, John C.
Blackmun, Robert L.	Brown, George E.
Boehme, Earl J.	Bullis, John A.
Bradford, Fred E.	Cardey, Norman L.
Briney, Allan K.	Case, Walter G.
Buehler, George S.	Cass, Donald
Bullock, Lewis T.	Cobley, George G.
Carter, Robert V.	Cole, Clifford B.
Cherry, Ian S.	Cole, Seymour L.
Cobb, Dudley M., Jr.	Compton, Richard B.
Conti, James G.	Crowe, Harold E.
Cook, Eugene Lee	Cruse, Donald R.
Cook, Wells C.	Doran, S. Mark
Cosgrove, Jay B.	Doyle, Patrick J.
Coumbe, Jay E.	Dresser, James T.
Craig, Lyle G.	Eder, David
Crane, Edward H., Jr.	Ellerbroek, Wallace C.
Crane, Jay J.	Ermini, Eugene D.
Crowl, Verne C.	Evans, William D.
Doehring, Paul C.	Failing, Joseph H.
Donath, Douglas	Fishel, Howard E.
D'Orazio, Edward	Fowler, John D.
Dorn, Robert M.	Frantz, Kieffer E.
Doyle, James C.	Frempter, George R.
Dummer, Jerome	Fusco, John A.
Earl, Donald H.	Gamble, Thomas J.
Einstein, Robert A. J.	Garvin, Harold W.
Eisele, Harold E.	Gelfand, Leo
Ekstrom, Carl F.	Gilbert, Wallace G.
Ewing, John Paul	Glazier, McCleery
Fitch, Donald R.	Gondek, Frank R.
Foster, P. A.	Goodwin, William E.
Frie, Robert James	Gray, F. Lyle
Gates, Earl F.	Grimaud, Harry J.
Gettelman, Eugene	Hadley, Russel C.
Gill, Charles C.	Haller, Austin P.
Glyn-Davies, Alex	Hanchett, Richard B.
Golden, Robert F.	Hanten, Stephen J.
Gooel, Elmer F.	Hare, Robert
Gummess, Glen H.	Harlan, Mahlon M.
Gunther, Lewis	Harris, George S.
Haining, Robert B.	Haskell, M. M.
Halasey, Thomas	Hastings, T. Newlin
Ham, Franklin F.	Hayes, Edward W., Jr.
Hamilton, John B.	Hertzog, Francis C.
Hartley, Philip B.	Hohl, Mason
Haschka, August J., Jr.	Huffman, L. Dale
Heiser, Saul	Hutter, Charles G.
Hickey, N. Glenn	Irwin, Ralph L.
Hill, Lowell R.	Isaacs, Julien H.
Hoffman, Eugene F.	Jackson, Douald W.
Holloway, James W.	Johnstone, Marshall W.
Hood, Robert T.	Kahlstrom, Samuel C.
Kaplan, Louis H.	Kaiser, J. Emil
Kempf, Paul Ruben, Jr.	Kalivas, George P.
Kidd, Thomas R.	Kantola, Bennett W.
King, Donald R.	Kelso, Raymond W., Jr.
Klingbeil, Jerome R.	Kirchner, Herbert J.
Knox, Stuart C.	Klemes, Marvin A.
Kuntz, George S.	Knox, John F.
Kuris, David B.	Kramer, Jack
LaForge, William C.	Lazarus, Maurice L.
Laughlin, T. Jackson	Linsman, Joseph F.
Leffingwell, F. E.	Lopez, Charles J.
Lloyd, O. Dale	Mack, Edward G.
Loopesko, Eugene	Mack, Marvin A.
Ludwig, J. Lafe	Mark, Jerome S.
Lynn, Theodore A.	Mason, Christopher A.
Macdonald, Ian	Masters, John B.
Matlock, Richard A.	McGirr, John I., Jr.
Mauer, Edgar F.	McLennan, Robert M.
Mayne, John C.	Mercer, Marshall M.
McCleery, Walter S.	Metson, Bates F.
McDowell, Allyn J.	Mietus, A. C.
McNeil, Robert J.	Morales, Fernando
McVann, Robert M.	Morgan, Frank M.
Michels, Arthur G.	Morrell, Charles F.
Miller, Richard D.	Mulford, Todd M.
Milliken, Ralph M.	Nickel, Vernon L.
Mooney, Herbert S.	O'Neil, Mervin B.
Morgan, Henry G.	Pabst, Paul J.
Mortensen, Elmer S.	Pallette, Edward C.
Mumler, William C.	Palmer, Jay J.
Murrieta, A. J., Jr.	Peeke, George O.
Neale, Roderick M.	Plimpton, Edwin B.

Delegates	*Alternates*
Los Angeles (continued)	
Neuenschwander, R. S.	Pollack, John V.
Nixon, Richard W.	Randle, Robert E.
Nugent, Maurice W.	Reeder, David H.
Oetting, Henry K.	Rolland, Ward M.
Parks, Ross V.	Rosenbloom, Nathan
Paxton, Frank F.	Rouff, Elliot A.
Penn, Sidney W.	Rubin, Herbert B.
Petersen, Harold E.	Schade, Frank F.
Pettit, Richard D.	Schimmel, Irwin
Pheasant. Homer C.	Scuderi, S. A.
Polito, S. Robert	Sheldon, David B.
Quinn, William F.	Slater, James L.
Randall, Morton H.	Smith, Thayer A.
Richards, Melvin R.	Soper, H. Vern
Rogers, Frank A.	Starr, Charles M.
Rolf, Bruce B.	Starr, Harvey E.
Romeo, Matthew P.	Statman, Solomon H.
Sampson, J. Philip	Steffen, Charles G.
Schroeder, Ralph L.	Stephens, John S.
Senseman, William R.	Stout, Carlyle F.
Sleeter, John W. H.	Taw, Richard L.
Smart, Reginald H.	Thom, John G.
Smith, Earl H.	Thompson, W. B., Jr.
Smitter, Robert C.	Thurber, Packard, Jr.
Sommer, Melvin L.	Treible, Dale P.
Stirrett. R. L.	Turbow, Arthur O.
Stout, Joseph H., Jr.	Turnbull, Fred M., Jr.
Tyroler. Frederic N.	Tyler, George C.
Van Dyke, H. Milton	Van Riesen, Milton H.
Ward, George H.	Wallace, Keith H.
Watson, Robert L., Jr.	Watson, Price T.
Weber, Robert A.	Watson, Robert Webster
Weekes. Leroy R.	Westphal, Edward A.
Weeks, William F.	Wilcox, John C.
Wieman, Walter H.	Wilkins, Harold E.
Wilson, Warren A.	Wood, Robert C.
Witherbee, Harold R.	Wunderlich, Edwin
Wood, Howard A.	Young, H. Mark
Woodruff, John H., Jr.	Zaro, John A., Jr.
Madera County (2)	
Daggett, Gilbert G.	Rowe, R. B.
Solberg, L. A.	Weinberger, Herbert
Marin County (4)	
Arons, Joseph J.	Hedin, Roger W.
Degenhardt, Ira	McGee, John
Manwaring, John H.	Schell, Robert
Smart, William	West, Robert C.
Mendocino-Lake County (2)	
Hill, Thomas P.	Curtis, Hugh P.
Smalley, Robert E.	Roberson, B. B.
Merced County (2)	
McDowell, B. E.	Holm, Richard P.
Medefind, J. N.	Udall, Addison R.
Monterey County (4)	
Clark, Howard E.	Hull, Osman H.
Englehorn, T. D.	Shebl, Joseph J.
Mitchell. Allen C.	Turner, Joseph E.
Moore, Chester G.	Turner, Seymour
Napa County (2)	
Brignoli, Walter H.	Ashley, Robert C.
Rose, Edgar Kash	Hemphill, Arthur C.
Orange County (12)	
Altman, Richard F.	Ball, Dexter T.
Donaldson, A. Norton	Ball, Robert E.
Galbraith, Harold F.	Gerrie, Wallace A.
Gendel, Samuel	Kornblum, William A.
Hanigan, Thomas E.	Lowe, Waynard W.
Hunt, Frederick T.	Mackey, Francis G.
Paul, Carl J.	McAllister, Cloyd N.
Pettis, Emmett M.	O'Brien, Frank T.
Price, J. B.	Plumb, Hugh J., Jr.
Struve, Edgar E.	Preston, Richard A.
Whittaker, L. F.	Specht, Oswald S.
Wilson, L. E.	Wineland, Richard E.
Placer-Nevada-Sierra County (2)	
Dubin, Nathan	Kindopp, D. M.
Joye, K. M.	Smith, F. Lynn
Riverside County (5)	
Abbott, Donald	Fitzmorris, Andrew
Batzle, J. Harold	Ivanoff, John
Garcia, Robert E.	Peterson, John R.
Hamilton, Van	Stone, Vean M.
Stone, H. H.	
Sacramento County (9)	
Berman, A. E.	Berg, John
Dozier, Dave F.	Cook, Orrin S.
Grayson, Charles E.	Demorest, Byron H.
Harding, William F. B.	Dowrie, James O.
Hickey, William C.	Janvier, Joel T.
Horn, Carl E.	Range, Robert L.
Martin, James W.	Ripple, Richard
Pope, Glenn A.	Schroeder, Fred
Yant, James H.	Wright, Carleton C.

Delegates	*Alternates*
San Benito County (2)	
Moore, Ernest	Haruff, John J.
Taylor, Kent	Quinn, Robert D.
San Bernardino County (7)	
Coughlin, John H.	Cover, William L.
Hadley, Carl M.	Crutcher, Luke
Martin, J. Needham	Halburg, C. T.
Melone, Frank C.	Hoag, L. G.
Miano, Ben D. A.	Marsh, Norman E.
Sprague, Charles P.	Ogden, Wendell L.
Varden, Arthur E.	Vargas, Roger A.
San Diego County (18)	
Carpenter, Walter F.	Averill, Roy S.
Fairchild, L. H.	Bethard, William F.
Feeney, Michael J.	Brumbaugh, Simon C., Jr.
Hall, Winston C.	Franklin, Roland G.
Hanna, Curtis M.	Heywood, Charles W.
Hokr, William K.	Hippen, Robert L.
Irwin, James B.	Merdinger, Walter F.
Isenhour, Roger C.	Messenger, Harold M.
King, Ralph M.	Miller, David
Levy, Edward I.	Moore, Stanley A.
Moore, A. E.	Peck, J. Haddon A., Jr.
Newman, Willard H.	Peck, Samuel G.
Phalen, James R.	Plumb, Robert T.
Robinson, Frank H.	Powell, E. R.
Rumsey, John M.	Pruett, Charles E.
Skeoch, Gordon D.	Rumsey, Eugene W.
Tancredi, Chester	Tabor, George L., Jr.
Telford, Joseph W.	Youel, Milo A.
San Francisco County (34)	
Beckh, Walter	Bailly, T. Edward, Jr.
Bonfilio, Nicholas D.	Castro, Amos J.
Burnham, DeWitt K.	Cohn, Bradford P.
Callaway, Claude P.	Cook, Robert E.
Campbell, Douglas G.	Cowan, John F.
Clark, Albert G.	Cron, Heinz E.
Clark, W. Dayton	Danno, Dorothy P.
Comba, Robert C.	Fitzgerald, William J.
Cox, Francis J.	Foster, Sidney E.
Fenlon, Roberta	Furlong, Joseph J.
Fraser, Alexander F.	Gallagher, Donald M.
Galgiani, John	Gobar, Robert F.
Garland, L. Henry	Greco, Vincent H.
Gibbons, Henry, III	Hartwig, Arthur R.
Herzog, George K., Jr.	Henry, Margaret
Hurwitz, Samuel	Herrod, Chester
Leach, Charles W.	Hopp, Eugene S.
Lebo, Charles	Jacobs, Alvin H.
Musser, Don C.	Long, Albert E.
Olney, Mary B.	McGregor, Mar W.
Pillsbury, Philip L.	Newsom, William A.
Rixford, Emmet L.	O'Gara, Louis A.
Robinson, Saul J.	Palmer, Richard
Rochex, Francis	Pearl, Felix
Saunders, John B. de C. M.	Salomon, Maurice S.
Schaupp, John B.	Sanazaro, Paul J.
Schaupp, Karl L., Jr.	Schaefer, Jane
Sirbu, Abraham B.	Strange, Vance M.
Watts, Malcolm S. M.	Talbott, Grace M.
Wayburn, Edgar	Thompson, James H.
Webb, Eugene M.	Thompson, Mary C.
Weyrauch, Helen B.	Trauner, Lawrence M.
Willett, Forrest M.	Wagner, William F.
Williams, A. Justin	Webb, Gilbert A.
San Joaquin County (4)	
Armanino, Louis P.	Blinn, John F., Jr.
Benn, James J.	Lee, Dora Ames
Mayo, John F.	McNally, John T.
Noetling, Paul R.	Powell, James R.
San Luis Obispo (2)	
Hardham, John	Scow, James
Middleton, Joseph G.	Tedone, L. M.
San Mateo County (10)	
Brown, Henry A.	Armstrong, Charles D.
Findley, John W.	Hart, Ward L.
Fox, Norman C.	Healy, Francis A.
Hills, Oscar W.	James, Robert E.
Holmes, Robert O.	Lindsey, Howard W.
Novak, Frank J.	Manry, Clayton H.
Ray, Hartzell H.	Moore, Ferrall H.
Saidy, John T.	Richanbach, Henry S.
Smith, Harry F.	Rossiter, Stanford B.
Thompson, William H.	Willey, Roger W.
Santa Barbara County (4)	
Freidell, H. Vernon	Alexander, Harold
Miles, Harold	Heiges, Laurence, Jr.
Olsen, Arthur	McNiece, Kenneth
Riparetti, P. Paul	Williams, Robert

Delegates	*Alternates*
Santa Clara County (15)	
Boice, Clyde	Bacci, Orval J.
Burchfiel, Robert	Besson, Gerald
Cary, J. Alison	Cramer, Harold
Clark, William H.	Kaufman, S. Fred
Dennis, Robert	Kelly, Allen
Elmore, Ernest F.	Kenter, Thomas P.
Foster, Thomas N.	LaVeque, Edgar G.
Fox, Leon P.	Meyer, Robert W.
Houck, George H.	Peck, Clemmer M.
Liston, Edward	Rugtiv, George M.
Mitchell, Sidney	Schilla, Frederick
Morton, Paul V.	Silver, Emmanuel
Olson, Raymond N.	Skillicorn, Stanley A.
Scarborough, C. Gerald	Wheat, Richard
Snyder, J. Frederic	Zobel, Jerome
Santa Cruz County (2)	
Newhall, Luther	Cress, William
Spencer, James A.	Crompton, Robert
Shasta-Trinity County (2)	
Martin, George A.	Fulton, Lee D.
Miller, Charles D.	Nilssen, William, Jr.
Siskiyou County (2)	
Bayuk, R. W.	Newton, A. H.
Reynolds, J. W.	Vidricksen, H. L.
Solano County (2)	
Garrett, Robert L.	Joseph, Herbert L.
Jones, F. Burton	Schmutz, Melvin A.
Sonoma County (3)	
Newman, William J.	Panting, Norman
Robbins, R. Dee	Salmon, Everett L.
Sharrocks, Horace F.	Zieber, R. L.
Stanislaus County (3)	
Hatch, Francis N.	Deyoe, George W.
Mew, David J.	Pyles, Gordon
Purvis, Robert	Ryan, William H.
Tehama County (2)	
Ingle, G. W.	Frey, Russell G.
Wolfe, L. E.	Wilson, E. R.
Tulare County (2)	
Feldmayer, James E.	Lavers, George
Karstaedt, Robert	Miller, Ralph N.
Ventura County (2)	
Helbling, Franklin K.	Huff, W. Cloyce
Moore, J. W.	Nelson, James H.
Yolo County (2)	
McKinney, Charles L.	Kennedy, James
Young, Corbin	Robinson, William
Yuba-Sutter-Colusa County (2)	
Heckman, John R.	Bradley, Herbert W.
Wallace, Robert	Williams, James D.

PAST PRESIDENTS (22)

Ewer, Edward N.	1925
Harris, Junius B.	1931
Reinle, George G.	1933
Peers, Robert A.	1935
Wilson, Harry H.	1940
Molony, William R., Sr.	1942
Schaupp, Karl L.	1943
Goin, Lowell S.	1944
McClendon, Sam J.	1946
Cline, John W.	1947
Askey, E. Vincent	1948
Kneeshaw, R. Stanley	1949
Cass, Donald	1950
MacLean, H. Gordon	1951
Alesen, Lewis A.	1952
Green, John W.	1953
Morrison, Arlo A.	1954
Shipman, Sidney J.	1955
Charnock, Donald A.	1956
MacDonald, Frank A.	1957
West, Francis E.	1958
Reynolds, T. Eric	1959

House of Delegates Agenda

1961 Annual Session

Embassy Room, Ambassador Hotel

Speaker.....James C. Doyle, Beverly Hills
Vice-Speaker.....Ivan C. Heron, San Francisco
Secretary.....Matthew N. Hosmer, San Francisco

FIRST MEETING

Saturday, April 29, at 3:00 p.m.

(To be recessed and reconvened at 9:30 a.m., Sunday, April 30)

ORDER OF BUSINESS

1. Call to order.
2. Report of Committee on Credentials, and Organization of the House of Delegates.
3. Roll call.
4. Announcement and approval of Reference Committees.
   (a) Committee on Credentials. (Delegates must register with the Committee.)
   (b) Reference Committee on the Reports of Officers, the Council, the Commissions, and Standing and Special Committees. (Reference Committee No. 1.)
   (c) Reference Committee on Finance, to review the reports of the Secretary and the Executive Secretary and to study and make recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year. (Reference Committee No. 2.)
   (d) Reference Committee on Resolutions and New and Miscellaneous Business. (Reference Committee No. 3.)
   (e) Reference Committee (No. 3A) on Resolutions and New and Miscellaneous Business.
   (f) Reference Committee on Amendments to the Constitution and By-Laws. (Reference Committee No. 4.)
   (g) Reference Committee on C.P.S. Business.
5. Address by President of the Woman's Auxiliary to the C.M.A.—Mrs. Samuel Gendel, Anaheim.
6. Address by President Paul D. Foster—Presentation of 50-Year Awards.
7. Miscellaneous announcements by the Speaker. (Stenographic service to secure copies of resolutions, etc.)
8. Report of the President—Paul D. Foster.
9. Report of the President-elect—Warren L. Bostick.
10. Report of the Speaker of the House of Delegates—James C. Doyle.
11. Report of the Vice-Speaker of the House of Delegates—Ivan C. Heron.
12. Report of the Trustees of the California Medical Association—Paul D. Foster.
13. Report of Physicians' Benevolence Fund, Inc.—Paul D. Foster, President.
14. Report of the Secretary—Matthew N. Hosmer.
15. Report of the Editor—Dwight L. Wilbur.
16. Report of the Executive Secretary—John Hunton.
17. Report of Legal Counsel—Peart, Baraty and Hassard.
18. Report of the Committee for Emergency Action—Paul D. Foster.
19. Report of the Council—Samuel R. Sherman, Chairman.
20. Report of C.P.S. Board of Trustees—A. A. Morrison, President.
21. Reports of Commissions.
   (a) Commission on Cancer—Burt L. Davis, Palo Alto.
      (1) Committee on Cancer Education—Sol Baker, Los Angeles.
      (2) Committee on Consultative Tumor Boards—Ian Macdonald, Los Angeles.
      (3) Committee on New and Unproved Methods of Cancer Treatment—James C. Doyle, Beverly Hills.
      (4) Committee on Special Cancer Programs—James Martin, Sacramento.
      (5) Committee on Tumor Tissue Registry—Justin J. Stein, Los Angeles.
   (b) Commission on Community Health Services—James MacLaggan, San Diego.
      (1) Committee on Allied Health Agencies—James MacLaggan, San Diego.
      (2) Committee on Blood Banks—James Moore, Ventura.
      (3) Committee on Disaster Medical Care—Justin J. Stein, Los Angeles.
      (4) Committee on Industrial Health—Packard Thurber, Jr., Los Angeles.
      (5) Committee on Rural and Community Health—Robb Smith, Orange Cove.
      (6) Committee on School Health—Charles A. Branthaver, Sacramento.
      (7) Committee on Traffic Safety—Joseph Maguire, Ventura.
   (c) Commission on Medical Education—Albert C. Daniels, San Francisco.

(1) Committee on Maternal and Child Care—James Ravenscroft, San Diego.

(2) Committee on Postgraduate Activities—Albert C. Daniels, San Francisco.

(3) Committee on Scientific Work—Albert C. Daniels, San Francisco.

(d) Commission on Medical Services—Donald C. Harrington, Stockton.

(1) Committee on Aging—Clarence H. Albaugh, Los Angeles.

(2) Committee on Fees—H. Dean Hoskins, Oakland.

(3) Committee on Government Financed Medical Care—John M. Rumsey, San Diego.

(a) Liaison Committee to the California Vocational Rehabilitation Service—Francis J. Cox, San Francisco.

(b) Liaison Committee to Department of Health, Education and Welfare—Malcolm C. Todd, Long Beach.

(c) Liaison Committee to Medicare and VA Home Town Care Program—John M. Rumsey, San Diego.

(d) Liaison Committee to State Department of Social Welfare—William F. Quinn, Los Angeles.

(4) Committee on Medical Care Insurance—Donald C. Harrington, Stockton.

(a) Subcommittee on Local Medical Society Sponsored Programs—John F. Murray, Fresno.

(b) Subcommittee on Miscellaneous Programs—Henry Gibbons, III, San Francisco.

(c) Subcommittee on Uniform Claim Forms—Dudley Cobb, Jr., Los Angeles.

(d) Liaison Committee to California Self-Insurers Association—Albert G. Miller, San Mateo.

(e) Liaison Committee to Insurance Industry—Joseph Telford, San Diego.

(5) Committee on Rehabilitation—Elizabeth Austin, Los Angeles.

(e) Commission on Professional Welfare—Arthur A. Kirchner, Los Angeles.

(1) Committee on Health and Accident Insurance—Homer C. Pheasant, Los Angeles.

(2) Committee on Private Practice of Medicine by Medical School Faculty Members—Werner Hoyt, Mt. Shasta.

(3) Medical Review and Advisory Board—Arthur A. Kirchner, Los Angeles.

(f) Commission on Public Agencies—Omer W. Wheeler, Riverside.

(1) Committee on Adoptions—George K. Herzog, Jr., San Francisco.

(2) Committee on Mental Health—Stuart Knox, Los Angeles.

(3) Committee on Other Professions—Wayne Pollock, Sacramento.

(4) Committee on State Medical Services—Omer W. Wheeler, Riverside.

(5) Committee on Veterans Affairs—Charles B. Hudson, Oakland.

(g) Commission on Public Policy—Dan O. Kilroy, Sacramento.

(1) Committee on Legislation—Dan O. Kilroy, Sacramento.

(2) Committee on Public Relations—Malcolm S. M. Watts, San Francisco.

(a) Sub-Committee on Radio, Television and Motion Pictures—John B. Schaupp, San Francisco.

(h) Judicial Commission—Donald A. Charnock, Los Angeles.

22. Reports of Other Committees.

(a) Advertising Committee—Robertson Ward, San Francisco.

(b) Bureau of Research and Planning—Donald D. Lum, Alameda.

(c) Finance Committee, Ivan C. Heron, San Francisco.

(d) Committee on History and Obituaries—J. Marion Read, San Francisco.

(e) Medical Executives Conference—Robert L. Wood, Jr., San Mateo.

(f) Delegates to the A.M.A.—Donald Cass, Los Angeles.

(g) Liaison Committee to C.P.S.—James C. MacLaggan, San Diego.

(h) Liaison Committee to the State Bar of California—Francis E. West, San Diego.

23. Old and Unfinished Business.

24. New Business.

SECOND MEETING

Tuesday, May 2, at 4:00 p.m.

(To be recessed and reconvened at 9:30 a.m., Wednesday, May 3)

ORDER OF BUSINESS

1. Call to order.
2. Supplemental report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of time and place for the 1962 annual session.
5. Election of officers:
   (a) President-elect.
   (b) Speaker.
   (c) Vice-speaker.
   (d) Councilors (three-year terms).
   (1) First District—James C. MacLaggan, San Diego (term expiring).
   First District—San Diego County.
   (2) Second District—Omer W. Wheeler, Riverside (term expiring).
   Second District—Imperial, Inyo, Mono, Orange, Riverside and San Bernardino counties.
   (3) Third District—Office No. 3—J. Norman O'Neill, Los Angeles (term expiring).
   Third District—Los Angeles County.
   (4) Third District—Office No. 6—Gerald W. Shaw, Santa Monica (term expiring).
   Third District—Los Angeles County.

(5) Fourth District—James W. Dalton, Santa Barbara (term expiring).
Fourth District—San Luis Obispo, Santa Barbara and Ventura counties.

(6) Sixth District—Office No. 1—Burt L. Davis, Palo Alto (term expiring).
Sixth District—Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz counties.

(7) Seventh District—Office No. 2—Donald M. Campbell, San Francisco (term expiring).
Seventh District—San Francisco County.

(8) Eighth District—Office No. 2—New Office—term expiring 1964.
Eighth District—Alameda and Contra Costa counties.

(e) Delegates to the American Medical Association: Delegates and Alternates to the American Medical Association are elected for terms of two calendar years. The Delegates and Alternates to be elected at this meeting will serve for two calendar years starting January 1, 1962.

Incumbents:

(1) Henry Gibbons III, San Francisco (term expiring).

(2) Sam J. McClendon, San Diego (term expiring).

(3) Eugene F. Hoffman, Los Angeles (term expiring).

(4) Warren L. Bostick, San Rafael (term expiring).

(5) J. B. Price, Santa Ana (term expiring).

(6) Frank A. MacDonald, Sacramento (term expiring).

(7) Paul D. Foster, Los Angeles (term expiring).

(8) Donald A. Charnock, Los Angeles (term expiring).

(9) New Office—term to start immediately, expire December 31, 1962.

(f) Alternates to the American Medical Association. All terms expiring. All offices for two-year terms starting January 1, 1962, except as noted:

(1) Claude P. Callaway, San Francisco (alternate to Henry Gibbons, III).

(2) John M. Rumsey, San Diego (alternate to Sam J. McClendon).

(3) Gerald W. Shaw, Santa Monica (alternate to Eugene F. Hoffman).

(4) Francis H. O'Neill, Eureka (alternate to Warren L. Bostick).

(5) Charles Hudson, Oakland (alternate to J. B. Price).

(6) J. E. Vaughan, Bakersfield (alternate to Frank A. MacDonald).

(7) Malcolm C. Todd, Long Beach (alternate to Paul D. Foster).

(8) Carl M. Hadley, San Bernardino (alternate to Donald A. Charnock).

(9) New Office—to start immediately, expire December 31, 1962.

6. Election of C.P.S. Trustees (three-year terms): Report of C.M.A. Council as Nominating Committee. Incumbents:

(a) Mr. Thomas Hadfield, San Francisco.

(b) Rt. Rev. Msgr. T. J. O'Dwyer, Los Angeles.

(c) Arlo A. Morrison, Ventura (not eligible for re-election).

(d) Dave F. Dozier, Sacramento (not eligible for re-election).

7. Announcement by Secretary.
Council's nominations of members of Commissions and Committees (for approval by the House of Delegates).

8. Reports of Reference Committees:

(a) Reports of Reference Committee No. 1 on Reports of Officers, the Council, Commission and Standing and Special Committees.

(b) Report of Reference Committee No. 2 on Reports of the Secretary, the Executive Secretary, and the budget and dues.

(c) Report of Reference Committee No. 3 on Resolutions and New and Miscellaneous Business.

(d) Report of Reference Committee No. 3A on Resolutions and New and Miscellaneous Business.

(e) Report of Reference Committee No. 4 on Amendments to the Constitution and By-Laws.

(f) Report of Reference Committee on C.P.S. Business.

9. Unfinished Business.

10. New Business.

11. Presentation of Officers:
President.
President-elect.
Speaker.
Vice-speaker.

12. Presentation of certificate to retiring president Paul D. Foster.

13. Approval of minutes. (Committee to edit.)

14. Adjournment.

JAMES C. DOYLE, *Speaker*
MATTHEW N. HOSMER, *Secretary*

PROPOSED CONSTITUTIONAL AMENDMENT

One proposed amendment to the Constitution of the California Medical Association was introduced in the 1960 House of Delegates. In accordance with requirements of the Constitution, this proposed amendment must lie on the table for one year, during which time it must be published in two issues of CALIFORNIA MEDICINE.

In the 1961 House of Delegates, this proposed amendment will be reviewed by a Reference Committee and reported back to the House of Delegates with the recommendation of that committee for approval or disapproval.

Proposed amendments to the Constitution may not be amended following their introduction but are voted on in the form in which they are introduced. A two-thirds affirmative vote in the House of Delegates is required for passage.

Author: C. J. Attwood.
Representing: Constitution Study Committee.

Resolved: That Article VIII, Section 3, of the Constitution be amended by deleting the final paragraph of the section, starting with the words "Further, such amendment . . ." and concluding with the words "prior to submission to the House of Delegates for vote." and substituting therefor the following:

"Further, such proposed amendment or amendments shall be referred to the appropriate reference committee, which shall hold hearings on the proposed amendment or amendments during the course of its regular business while the Association is in convention.

"If the proposal or proposals are introduced during the first meeting of the House, hearings shall be held at both the current and the next regular session. In this event, the reference committee shall report at a subsequent meeting of the House at the current session its findings and recommendations on the proposed amendment or amendments; this report shall be solely for the guidance of the reference committee and the House at the regular session at which the amendment or amendments are to be subject to vote. The reference committee at the current session may, with the consent of the author of proposed amendment or amendments, alter, amend or modify the proposed amendment or amendments and offer such altered version at a later meeting during the current session, together with its recommendations thereon.

"If the proposal or proposals are introduced during the second meeting of the House, hearings on them shall be held at the next regular session, prior to their submission to the House of Delegates for vote."

PRESIDENTS' DINNER DANCE

SUNDAY, APRIL 30

Cocoanut Grove, Ambassador Hotel

Reception, 7 p.m., Embassy Room **Dinner Dance, 8 p.m., Cocoanut Grove**

Formal dress optional

Tickets will be on sale in the Main Lobby

REGISTRATION

Registration and information desks are located in the Ballroom Foyer, Casino Floor. *All members, guests, and visitors are requested to register immediately on arrival.* There is no charge for registration except for Postgraduate Courses. Registration desks are open Saturday through Wednesday. *Admission to the general and section sessions and exhibit areas is by badge only.*

PRE-CONVENTION REPORTS

Officers • Commissions • Committees

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the House of Delegates:

To have had the privilege of serving as President of the California Medical Association is an honor I shall always remember.

The many friends I have made in all parts of the state, I shall always cherish.

If it can be said that my efforts on behalf of our beloved profession have, in some small way, been successful, I shall, for the rest of my life, feel more than amply repaid.

A visit to the San Diego County Medical Society in January completed my tour to all of the component county societies during my terms as President-Elect and President of the Association.

It should be reassuring to the members of the House to know that in nearly every county, physicians are, of course, meeting their responsibilities to their patients while additionally, they are taking part in the many local activities to earn for themselves the title of "physicians to the community."

Membership on the Governor's Committee on the Study of Medical Aid and Health took an excessive amount of my time during almost all of 1960.

Along with my other medical confreres on the committee, in my opinion, we exercised considerable leadership in matters of prime importance to the public and to the profession.

The final report of the committee was, therefore, devoid of some of the impractical suggestions which confronted us throughout most of our deliberations.

Mr. Howard Hassard, legal counsel, Mr. Robert Thomas and others of C.M.A.'s capable staff were of inestimable value to the committee members serving medicine in our deliberations.

Going on the basis that only an informed membership can make reasonable and intelligent decisions on the many matters so vital to the success of the California profession, I have, during the past year, distributed a great amount of information in the form of "Reports."

A careful reading of the reports, I believe, will make the deliberations of the House more meaningful and more constructive; this without the introduction of extraneous matters.

As President of the Association, I took part in many discussions relative to the question of medical care of the aging.

One trip involved bringing C.M.A.'s views to the officials of our American Medical Association.

This effort had its effect on the resolutions on elder care passed by the House of Delegates of A.M.A. and, to a degree, had a certain impact in passing the A.M.A.-supported Kerr-Mills Bill at the final session of the 1960 Congress.

During my term of office I have consulted with all of the committees conducting the affairs of the organization.

To mention them all would be impossible at this time. I am, however, very pleased with the constructive progress exhibited by the physicians who produced the revised Relative Value Study, the work of the doctors in the field of aging, public relations, public policy, medical education, cancer, allied professions, research and planning, to name but a few. It should be noted that a total of 586 devoted physicians serve on 65 C.M.A. commissions and committees.

The Trustees of the California Medical Association is a California nonprofit corporation which is designed to act as a holding company for surplus assets of the Association. It has existed for more than 30 years and has served during that period as a repository for surplus funds, a source of credit and a deterrent against unwise use of C.M.A. assets.

The members of the corporation are at all times the members of the C.M.A. Council, which is given complete authority over the appropriation of Association moneys. The deterrent effect mentioned here lies only in the fact that proposals which require funds in excess of those currently available must, to merit the approval of the Trustees, undergo a second evaluation by this second body. This provides, in effect, a "second reading" from which new and different standards of approval may emerge from those originally considered.

On another page of this issue will be found the financial reports of the corporation, which are broken down to show the overall financial status and the operations of the 693 Sutter Building as an operating entity.

During 1960 the corporation has provided financing for the C.M.A. through use of its borrowing power. The C.M.A. initiates its new budget on July 1 of each year, but does not start collecting the dues to meet that budget until the following January 1. During the final months of the year the corporation is able to borrow the needed operating funds and lend them to the Association. In the spring months, when dues are being received, these loans are retired.

Also during 1960, the Trustees voted to retire the life insurance policies carried on several key employees and to apply the proceeds against the funding costs for a new employee retirement program which will encompass all C.M.A. employees and which will necessarily be carried by the Association as the employer. This plan should be in effect by the time of the 1961 Annual Session.

The April 30 to May 3, 1961 meeting of the House of Delegates will be confronted with many vital problems. I shall name but two:

Progress on the proposed amalgamation with the members of the California Osteopathic Association is moving forward. The results of the C.M.A.-C.O.A. deliberations, as mentioned in my letter to the entire membership, will be presented to the House. The advantages to the public and to the professions will, I believe, be very clear by that time.

The results of the White House Conference on Aging, January 9 to 19, 1961, left much to be desired.

It should be remembered, however, that physicians were greatly outnumbered at the conference; that the social security recommendations could well have been expected considering the complexion of the attendees and how they were named.

The recommendations, therefore, can in *no way* be considered a congressional "mandate."

The profession, if I understand the determination of my fellow physicians will, at the meeting of the House, reaffirm

our complete opposition to this drastic attempt at the socialization of our profession.

During the past year, Mr. Hassard, in his capacity as executive director of C.M.A., has made certain realignments in staff personnel. The eventual results will be to bring greater C.M.A. service to the various county societies through the assignment of "contact men" for natural geographic areas.

This, it should be noted, is the acceptance of additional responsibilities by the already busy staff.

To these men I offer my sincere appreciation.

And I reserve a special thanks for the year of cooperation by the general officers and the district councilors who have labored long and tirelessly for the welfare of the members of what is now the second largest state association in the nation.

Respectfully submitted,

PAUL D. FOSTER, *President*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

The President-Elect office serves the function not only of preparing the candidate for assuming the next position with more knowledge and background, but also to provide an opportunity for direct communication with society members during the various county visits. The communication is clearly in both directions, from the membership to him with his subsequent opportunity to report to the Council, and from him to the membership with presentation of recent major problems and basic trends in medicine's relationship to citizens.

The President-Elect's main contact has for several years been in the northern counties with the southern counties, below Bakersfield, traditionally being reserved for the visits of the President. Although some thirty-four counties have been visited, which represented considerable effort, it is nonetheless my strong feeling that this has been most worthwhile. Throughout the reception has been cordial, the attitude serious, and our members inquisitive, alert, and dedicated. It has been the conclusion of this officer that those visits which included also the attendance of the Auxiliary were more worthwhile, not only because of their increased numbers but also the important contact with the Woman's Auxiliary and the opportunity to impart to them a resume of the major attitudes and activities of your medical society.

This year I had an opportunity to visit as a guest, several of the district societies of the Los Angeles County Medical Association. I considered this a very desirable advantage since many of them are very large, larger even than many of our independent, component county societies. In the next year I hope to have an opportunity to meet with more of these most stimulating groups.

As has been the case in many recent years, the major emphasis has been on socio-economic problems, particularly as related to the insurance mechanism, the provision of medical services to particular segments of society, the general problem of quality control, hospital relations and the control and maintenance of standards of physicians' practice. The major trends in this direction have been entirely satisfactory. Communications, in both directions from society to individual member and vice versa, remain the single, most important still unresolved problem. It is absolutely essential that the full energies of this society must be directed towards improving those communications.

Respectfully submitted,

WARREN L. BOSTICK, M.D.
President-Elect

REPORT OF THE SPEAKER AND VICE-SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

Your Speaker and Vice-Speaker sincerely appreciate your confidence in affording them the opportunity to serve and represent the House of Delegates and the California Medical Association. We have attended all of the Council and numerous other committee meetings throughout the year.

For the Annual Session of 1961, we have rearranged the schedule of meetings of the House of Delegates in order to provide more time for the delegates to attend the scientific sessions, and to initiate deliberations on the reports of Reference Committees at an earlier hour. The first meeting will convene Saturday, April 29th at 3:00 p.m. and should be completed in time for dinner. The second meeting will convene Sunday morning at 9:30 a.m. (Daylight Saving Time), probably finishing about noon. Our third meeting will be called to order Tuesday afternoon at 4:00 p.m. for elections and terminate in time for dinner. The last, and fourth meeting, will be Wednesday morning at 9:30 a.m. and should permit the business of the House to be transacted by luncheon time, or early afternoon. Because of this, delegates should be able to remain until the meeting is completed. Additionally beneficial will be the discussions on the Resolutions coming earlier in the day when everyone is less tired. We sincerely hope this will provide a more efficient agenda for all concerned.

Your Speaker and Vice-Speaker are most happy to follow the recommendations of the House of Delegates at all times. Thus, the Santa Clara County Resolution No. 38 calling for the seating of alternate delegates with the delegates will go into effect at this meeting. In order to do so, it will be necessary to remove the tables. This inconvenience is readily understandable in view of our numbers. This year we have 14 additional delegates, two additional councilors, and one additional past president, constituting a total of 405 members, not including the alternates. Obviously with the growth of our association, and the difficulties of providing a larger auditorium, we must consider some method of reducing the size of the House.

It is not too early for the respective county medical societies to be thinking of resolutions you wish introduced. Six copies should be submitted to the California Medical Association office, preferably 30 days in advance of our meeting. This does not preclude their submission at any time prior, or even on the floor of the House, once convened. However, resolutions sent in beforehand immeasurably facilitate the work of the C.M.A. staff. Should the number of resolutions to be submitted warrant, Committees 3A and 3B will be reactivated to carry the additional volume of work.

Your Speaker and Vice-Speaker enjoy to the utmost the cordial and cooperative spirit existing between the House and the chair. We encourage constructive suggestions and recommendations. We will, to the best of our ability, perform our tasks in a humble, honest and democratic manner.

Respectfully submitted,

JAMES C. DOYLE, *Speaker*
IVAN C. HERON, *Vice-Speaker*

REPORT OF THE PHYSICIANS' BENEVOLENCE FUND, INC.

To the House of Delegates:

Physicians' Benevolence Fund, Inc., is the outgrowth of a fund established by the House of Delegates in 1940. Its function is to provide financial assistance for needy physicians or their families.

This financial aid is usually extended for temporary periods and is intended to supplement and not supplant other sources of income. The fund, by the decision of its own operating committee, is not intended as a retirement fund.

During the past year the fund has contributed to the maintenance of several physicians and two widows. In addition, it has supplied $6,000 to Los Angeles Physicians' Aid, which maintains a retirement home and is currently building a nursing home for physicians and their families in Los Angeles.

The fund has also advanced a loan of $50,000, secured by real estate, to Los Angeles Physicians' Aid. This loan carries 2½ per cent annual interest and is repayable in quarterly installments which will start on September 1, 1961.

Financing of the fund comes from the allocation of one dollar from the annual dues of each C.M.A. member, together with contributions from the Woman's Auxiliary and from earnings on investments. In the fiscal year ended June 30, 1960, the C.M.A. contributed $16,703 from dues, the Woman's Auxiliary donated $2,766 and income on investments amounted to $2,872. Total income was $22,641.

Expenditures, including $327 of operating costs, amounted to $16,526, leaving a surplus of income over expenditures of $6,389, including $300 returned to the fund by one beneficiary who regained his own earning capacity during the year.

At the close of the fiscal year the fund showed total assets of $121,889, of which $93,153 was invested in government securities.

The operating committee for this fund is made up of Doctors Ford P. Cady and Elizabeth Mason-Hohl of Los Angeles, Don C. Musser of San Francisco, Clyde L. Boice of Santa Clara and George C. Wolf of Fresno County. The members of this committee have been most prompt and understanding when appeals for assistance have been received and our thanks go to them for their unselfish devotion to this charitable enterprise. The staff of the C.M.A. handles all operating details and the only cost of administration is a modest professional fee for auditing the books each year.

Our thanks also go to the Woman's Auxiliary for its continued financial support and its willingness to investigate needy cases. We should also thank the personal physicians of our needy members and their families, who have consistently and anonymously furnished their own services to these people and kept the fund advised on the physical needs and outlook for these recipients.

Respectfully submitted,

PAUL D. FOSTER, *President*

REPORT OF THE SECRETARY

To the President and the House of Delegates:

I have attended all of the meetings and carried out the duties of secretary as designated by the Constitution as well as the duties assigned to me by the Council.

Respectfully submitted,

MATTHEW N. HOSMER, *Secretary*

REPORT OF THE EDITOR

To the President and the House of Delegates:

Although feeling no compulsion to make changes merely for the sake of change, the editor of CALIFORNIA MEDICINE, reviewing the past year in preparing to make his annual report to the membership, found himself looking back over a period in which not much happened to your journal save for a slow accretion of stature among medical publications. This view is one to suggest consideration anew of things that might be done to make CALIFORNIA MEDICINE a better instrument of communication and one that the members of our Association may think of with conscious pride. Matters of content, of format and of exterior dress will be deliberately examined in that light in the year ahead.

The stature of a publication is difficult to measure, but one gauge of the progress of your journal is the number and the quality of manuscripts submitted to it. In this regard it is heartening to report, at a time that many state journals are complaining of a decrease in the number of articles submitted for publication, that CALIFORNIA MEDICINE continues to receive almost twice as many as it publishes. Moreover, some of those submitted but not accepted are rejected not because of lack of merit but because they are considered too specialized or too much like others that are already in inventory awaiting publication. Indeed, many of that order are later published in other journals.

CALIFORNIA MEDICINE publishes about half of the papers read at the Annual Session of the California Medical Association and about the same proportion of the manuscripts that are offered through other channels.

Your journal continues to occupy a respected position among the journals of state medical associations, and again the editor wishes to express his thanks to the persons who help to keep it there. Besides those whose names are on the masthead and on the roster of the Editorial Board, there are many others who serve anonymously—reviewing books, writing reports, advising as to manuscripts of a special nature. A debt to them is here gratefully acknowledged. Sincere thanks go again to Robert Edwards, who as assistant to the Editor, continues to play an increasingly important role in making CALIFORNIA MEDICINE an outstanding journal. To Mrs. Barbara Rooney who so successfully watches the countless details in the editorial office and to John Hunton who has contributed numerous good editorials go the gratitude and appreciation of the Editor.

Respectfully submitted,

DWIGHT L. WILBUR, *Editor*

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

This report is drafted by the executive secretary but in reality represents the entire staff of the Association and is submitted in their behalf.

The California Medical Association has undergone a large and rapid expansion in the past two years. It has undertaken new and empirical activities, has established a strong system of activities under a number of commissions and committees and has, of necessity, set up a new and larger household. This expansion has been noted in a large increase in staff and in higher monetary outlays for personnel, equipment, travel, meeting cost and all the other items that enter into the overall budget of the Association.

The endeavor on the part of the staff has been to provide for an orderly growth, without waste, and with maximum efficiency. Along these lines, the transition from a relatively small office to a considerably larger operation has been essentially a smooth one.

On this base, this report will proceed in detailed sections, as outlined below. It is hoped that all members of the House of Delegates and of the Association will feel free to attend the meetings of the reference committee which discusses

this report and will raise all questions on which additional information is required.

1. *Administrative.* The Association has now been installed in its new quarters for more than one year. While the move entailed a number of problems and while a shaking-down period has been necessary, the office setup today is essentially complete, comfortable and efficient. Offices have been arranged to group allied activities together, such as administration, commission and committee work, publication, etc.

A central filing room has been set up and a new filing system is being installed. Membership and bookkeeping activities, which grow in direct proportion to the growth in membership, have been expanded to meet the increase in volume. A new filing system for members' records of membership and accounts has been installed and gauged to accommodate anticipated growth in the future.

Telephone services provide intercommunications throughout the building and a new type of switchboard for incoming calls only frees the telephone operator for other duties.

New equipment, including a multilith machine, a new high-speed Addressograph and a new Graphotype for preparing mailing plates, is in operation and functioning well. Members may be interested to know that as many as 500,000 printed pages are produced in some months and that the number of pieces of mail addressed monthly runs into the hundreds of thousands. This volume requires careful scheduling and the establishment of a priority system of dates as a means of guaranteeing production of all projects at the desired time.

2. *Personnel.* The C.M.A. staff now includes 14 full-time and three part-time administrative employees and 32 clerical employees, the latter including one janitor and two part-time employees. These figures include two administrative and two clerical employees in the Los Angeles office.

Administrative employees in San Francisco include a new executive in the public relations department, a new director of research and eight new clerical employees. New employees have been added as required. As each new administrative position is created, a new clerical employee is required. In addition, an increasing volume of work has necessitated the addition of several employees to handle unwieldy workloads in some areas. It is believed that the present staff is adequate at this time and for the foreseeable future if the present program of the Association remains in effect. With additional projects, additional employees are required.

An idea of the growth of C.M.A. staff in recent years may be gained by the comparative figures shown below. These are employee totals, administrative and clerical, as of December 1 of 1960, 1958 and 1955:

	1960	*1958*	*1955*
Administrative	17	11	10
Clerical	32	19	15

3. *Membership.* Membership in the Association continued to grow in 1960 but the rate of growth was somewhat lower than in earlier years. Membership totals, showing the number of active members by counties as of November 1, 1960, and a year earlier, are shown below. It should be noted that 30 of the 40 county societies registered a gain in membership in the years compared, while six societies showed a loss and four reported no change. A year ago the same comparison showed 33 societies with membership gains, three with losses and four with no change. Percentagewise, the gain in active members in 1960 was 3.55 per cent, compared with 4.54 per cent for the preceding year and 4.20 per cent for the 1958 period.

ACTIVE MEMBERSHIP IN THE C.M.A. BY COUNTY SOCIETIES

	Nov. 1, 1959	*Nov. 1, 1960*
Alameda-Contra Costa	1,401	1,504
Butte-Glenn	84	86
Fresno	277	276
Humboldt-Del Norte	86	91
Imperial	54	52
Inyo-Mono	9	9
Kern	212	230
Kings	36	34
Lassen-Plumas-Modoc	26	27
Los Angeles	6,920	7,094
Madera	16	18
Marin	180	184
Mendocino-Lake	59	55
Merced	56	58
Monterey	184	184
Napa	81	80
Orange	541	587
Placer-Nevada-Sierra	69	72
Riverside	213	236
Sacramento	423	429
San Benito	12	11
San Bernardino	356	366
San Diego	871	912
San Francisco	1,673	1,728
San Joaquin	210	219
San Luis Obispo	84	86
San Mateo	507	507
Santa Barbara	217	225
Santa Clara	707	755
Santa Cruz	94	98
Shasta-Trinity	62	68
Siskiyou	22	23
Solano	73	74
Sonoma	166	168
Stanislaus	155	164
Tehama	17	17
Tulare	113	114
Ventura	118	123
Yolo	45	48
Yuba-Sutter-Colusa	53	55
TOTAL	16,482	17,067

4. *Financial.* Balance sheets and operating statements for the Association and for Trustees of the C.M.A. and Physicians' Benevolence Fund, Inc., appear elsewhere in this issue under the report of the Finance Committee. Books and accounts of all three entities are maintained by C.M.A. staff members and no charges are made to the subsidiaries for this service.

For the fiscal year ended June 30, 1960, the Association again operated at a deficit. The net deficit for the year was $20,054, compared with a deficit of $49,329 for the preceding fiscal year and a deficit of $40,402 for the 1958 fiscal year.

Income from dues for the 1960 fiscal period was $840,266, a gain of 13.7 per cent from the $732,058 for the preceding year. This increase reflects both a 10 per cent increase in the level of dues and a membership gain.

Income from postgraduate courses was $12,445, a decrease of 34.9 per cent from the preceding year. Advertising income was $234,007, up 22.4 per cent from the 1959 period.

Expenses for the 1960 fiscal year are shown in detail in the Finance Committee report on another page. In brief, administrative costs for the year were up 37.4 per cent, the costs of scientific, educational and public relations activities were 1 per cent lower than in the preceding year, and the costs of CALIFORNIA MEDICINE were up 8.4 per cent. In the case of the journal, income was sufficiently above the increased costs to return a surplus from the publication, without crediting dues income, for the first time in its history. It is hoped that this condition may be maintained so that the journal may stand completely on its own feet financially.

The increase in administrative costs, amounting to $104,313 over the preceding fiscal year, represents increased costs in nearly every item of expense. The greatest part of this increase resulted from the move to new quarters and to the expanded operations of the Association. Close to $35,000 of

the increase was in the form of furniture and equipment purchased for the new headquarters; practically all of this is nonrecurring and will not be reflected in future budgets. In addition, the costs of rent, postage, telephone, office supplies, etc., were greater because of the need of preparing new forms, providing office communications and meeting increased mailing demands.

To meet these increased costs, particularly in the six months of the calendar year preceding the collection of dues, the Association has had to resort to borrowing. A line of credit has been established at the bank by the Trustees of the C.M.A., using securities as collateral, and interfund lending and borrowing at nominal interest rates provides operating funds. Such borrowing takes place in the closing months of the calendar year and repayment is made in the spring months. At the close of 1960 bank loans amounted to $420,000. The Finance Committee has reported to the Council that this amounts to approximately $25 per active member but no proposals have been made to raise this sum to eliminate borrowing.

A budget for the 1961-1962 fiscal year will be prepared for the Finance Committee and the Council, to be approved by these bodies before being submitted to the 1961 House of Delegates.

5. CALIFORNIA MEDICINE. The journal continues to occupy a high position among state and regional medical journals. The editor constantly strives for improved editorial content and currently, through the ad hoc Committee on Scientific Activities, is exploring future possibilities for CALIFORNIA MEDICINE. Improvements in format and presentation of material are made when and where indicated and it is gratifying to note that some innovations here are emulated by other publishers.

In the field of advertising, the journal enjoyed a record year in income. This is attributed almost entirely to an upward revision of advertising rates, in line with increased circulation. In advertising volume, there now appears to be a decrease from the level established in 1959. Part of this is due to the critical standards applied by the Advertising Committee and part to what appears to be a lessening of promotional effort by pharmaceutical producers. It appears that hearings by a Senate committee into drug promotion and pricing may have caused some producers to retrench in the promotion of their products. Just what turn this trend may take in the future is not discernible at this time. Meanwhile, economies in production operations of the journal have kept total costs within reasonable levels and, in some instances, have permitted actual savings to the advertiser and the publisher alike.

6. *Annual Session.* Arrangements are practically complete at the end of 1960 for the 1961 Annual Session. Through a suggestion from the staff, the Council has approved the separation of both the first and second meetings of the House of Delegates into two sections. Under this arrangement, the House will meet on April 29 for the reports of officers and guests and the carrying out of routine business items. It will then recess until Sunday morning, April 30, for the introduction of new business. Reference committees will then meet. For the final meeting, a session will be held on Tuesday, May 2, for elections. The House will then recess until Wednesday, May 3, at which time it will consider the reference committee reports and hold its closing ceremonies. This arrangement is calculated to eliminate tediously long meetings and to provide adequate time for reference committees to complete their work.

In addition, several innovations will be made in an effort to facilitate and expedite the work of the House and its committees.

The Association is still plagued with the lack of adequate space under one roof for an Annual Session. At the Ambassador Hotel in Los Angeles it is necessary to budget space very closely to meet as many demands as possible. Even then, space is not available for all acceptable scientific exhibits or for organizational exhibits of the Association and its allied organizations. The situation will be magnified in San Francisco in 1962, when space will be required in two hotels and possibly in nearby auditoriums.

7. *Staff Comments.* The growth of the C.M.A. staff in recent years has been outlined earlier in this report. It should be emphasized here that the increase in staff composition has come about not from empire-building within the staff but from the need to carry out functions which the House of Delegates, the Council and the commissions have approved. A review of the budget for each year will demonstrate the breakdown of activities among the various commissions and permit an evaluation of the cost and the returns to the Association from any selected program. In round figures, the addition of one administrative staff member at an annual salary of $12,000 means a total added cost of about $25,000 a year when rent, supplies, secretarial assistance, travel, etc., are considered. It is believed at this time that the Association has a dedicated and efficient staff, adequate for present activities. Members of the House of Delegates will, however, want to bear in mind the added costs which are necessitated when new programs or projects are voted.

During 1960, Mr. Bill Tobitt was added to the staff to handle radio and television matters and to assist in other work in public relations. Late in the year Mr. Murray Klutch was employed as director of research for the Bureau of Research and Planning. In addition, several additional clerical employees have been obtained to meet an increasing workload throughout the organization.

In behalf of the entire staff, may I thank the Officers, Councilors and commission-committee chairmen and members with whom we are privileged to work. A mutally cooperative attitude is prevalent throughout the C.M.A. and it is only under such circumstances that an effective and efficient operation of this magnitude can be attained.

Respectfully submitted,

JOHN HUNTON, *Executive Secretary*

REPORT OF LEGAL COUNSEL

To the President and the House of Delegates:

The Legal Department submits the following report covering the interval between the 1960 annual session in February and the time of the submission of this report.

There has been attendance at the annual session and at all meetings of the Council, various commissions, standing committees, special committees of the Association as well as many committee hearings at the State Legislature; many reports have been prepared and submitted and many opinions given on a number of subjects, as requested by the Association, its officers and committees as well as its members and its component societies; several articles have also been written for CALIFORNIA MEDICINE.

In the field of legal liability for personal injuries, the outstanding development during the past year was the decision of our California Appellate Courts in the Cutter Laboratories case. A number of damage suits have been brought against Cutter Laboratories arising out of the fact that one of the early batches of Cutter Salk vaccine apparently contained live virus which resulted in a number of cases of poliomyelitis. The first of these cases was tried in Oakland about two years ago. The plaintiff asserted two legal theories of liability, as follows: (1) That Cutter Laboratories was negligent in the manufacture of the vaccine and (2) that independent of negligence, Cutter Laboratories impliedly

warranted that its vaccine was "fit for the purpose intended," namely, prevention of poliomyelitis. The jury expressly found that Cutter was *not* negligent. However, the jury also found that under the law as expounded to it by the judge, it had to find that Cutter had violated the implied warranty.

On appeal, our District Court of Appeal affirmed the damage award against Cutter and established as the law in California that a manufacturer of pharmaceutical products impliedly warrants that such products are fit for the purpose intended. Our Supreme Court concurred in the conclusions reached by the District Court of Appeal.

The case has been reviewed in detail in CALIFORNIA MEDICINE, December, 1960, at page 376.

The legal doctrine of implied warranty, which applies to the sale of goods, is obviously being extended by the courts into new areas. The Cutter decision is the first application of implied warranty to pharmaceutical or biological products. If it is further extended in the field of medical care it could have a profound effect upon the practice of medicine. Meantime, however, it must be noted that the physicians who administered Cutter's Salk vaccine have not been sued. All of the lawsuits have been aimed directly at the source of the material—Cutter Laboratories.

We have a number of other matters to report to the House of Delegates, not only in the field of professional liability but also in other areas of the law that affect the practice of medicine. However, due to the nature of the items involved and the desirability of submitting current information to the House, we will not pursue these subjects any further at this time but instead will seek permission of the Speaker to submit a supplementary report at the first meeting of the House at the 1961 Session.

During the year we have appeared before a number of county medical societies to speak on various subjects, and have also appeared as guest speaker at joint medical-legal meetings at Kansas City and Salt Lake City and at the annual State Bar meeting of the Michigan State Bar.

Numerous other matters involving the Association have arisen during the past year. In addition to the writer of this report, Messrs. Alan L. Bonnington, Robert D. Huber and Salvatore Bossio of our firm have devoted a great deal of time and effort to the legal affairs of the Association throughout the year. Much credit is due them.

It is a pleasure to be of service to the medical profession in California.

Respectfully submitted,

PEART, BARATY & HASSARD
By: HOWARD HASSARD

REPORT OF THE COMMITTEE FOR EMERGENCY ACTION

To the House of Delegates:

The Committee for Emergency Action was created several years ago to succeed to the functions of the former Executive Committee. Its members are the President, the President-elect, the Council chairman and the Speaker of the House of Delegates. These four officials, who sit with the Council in all its deliberations, are entrusted with final approval of items which the Council has approved in principle but not in detail. They are also assigned additional tasks by the Council from time to time and they constitute a small group which can be called together for personal or telephone conference meetings with a minimum loss of time in the event a speedy decision is needed.

The recommendations of the committee are subject to approval by the Council at its next succeeding meeting and are printed as a part of the Council minutes.

During the past year the committee has met on several occasions and reached decisions which have subsequently met with Council approval. The availability of such a committee can be of great help to the Council by providing a standby force which can work out details of programs and can speak with authority for the larger body, the Council, when rapid action is needed. These functions have been carried out faithfully during 1960.

Respectfully submitted,

PAUL D. FOSTER, *Chairman*

REPORT OF THE COUNCIL

To the President and the House of Delegates:

The Council has held eight meetings between the close of the 1960 Annual Session and the end of calendar year 1960. Two of these have been two-day sessions. Further meetings are scheduled for each month between January 1 and the time of the 1961 Annual Session.

Minutes of each meeting have been published in CALIFORNIA MEDICINE for the information of all members of the Association. In addition, preliminary drafts of all Council minutes are sent regularly to all county society presidents, secretaries and executive secretaries. For the further convenience of the county societies, a concise digest of the principal actions taken at each Council meeting is prepared in the days immediately following each meeting and sent to the county societies under the heading "Council Hi-Lites." Several societies have found these useful for publication in their bulletins.

Many Council actions have been concerned with reports and recommendations by the various commissions and committees. Details on such matters will be found in the reports of the commissions and their subcommittees. The purpose of this report is to highlight the principal items of business transacted by the Council during the year. Where further details are requested, Council members will be available before the reference committees during the 1961 Annual Session.

1. *Resolutions of the 1960 House of Delegates.*

The 1960 House of Delegates voted to refer to the Council six resolutions introduced in that session. The following actions were taken by the Council:

Resolution No. 16—Compensation of interns and residents. Referred to the Liaison Committee with the California Hospital Association. Discussions under way.

Resolution No. 23—Legal immunity for members of tissue and similar committees. Referred to Liaison Committee with California Hospital Association. Agreement reached that legislation should be introduced. Bill prepared and now under study for approval for introduction into Legislature.

Resolution No. 36—House Joint Resolution No. 23. Tabled.

Resolution No. 37—Legislation on hypnosis. Referred to Committee on Mental Health. Under study in committee.

Resolution No. 40—Fall-out shelters. Referred to Committee on Disaster Medical Care. Under consideration by committee.

Resolution No. 48—Insurance mediation committees. Referred to Commission on Medical Services, which has advised Health Insurance Council of the availability of county society mediation committees.

In addition to the resolutions referred directly to it by the House of Delegates, all resolutions from the session were reviewed by the Council and referred to appropriate committees or other action taken. Reports on resolutions referred to commissions and committees will appear in their respective reports. Nine resolutions not so referred but call-

ing for action were ordered activated by the staff. These were Resolutions Nos. 4, 8, 32, 33, 34, 35, 38, 41 and 71.

Resolution No. 74 was referred to the Speaker of the House of Delegates. Nine resolutions, numbers 30, 47, 48, 51, 59, 62, 65, 68 and 73, were referred to the Commission on Medical Services. In addition, numbers 6, 13, 57, 75 and 76 were referred to the Liaison Committee between the Commission on Medical Services and California Physicians Service. Twelve resolutions, numbers 3, 5, 7, 10, 11, 12, 14, 18, 29, 31, 45 and 46, were referred to the Board of Trustees of C. P. S.

Other resolutions were referred to specified commissions and committees, which will report on them. A complete report on the actions and referrals taken by the Council appeared in the Council minutes covering the March 26, 1960, meeting.

2. *Departments of the State of California.*

Throughout the year the Council has been privileged to have representatives of the State Department of Public Health, State Department of Mental Hygiene and State Department of Social Welfare attend Council meetings, report on current topics and extend the cooperation of these important activities to the Association. Participation by the state in medical practice covers a wide field and assumes a growing importance in terms of the total medical practice. Through the cooperation of the major departments controlling such practice the Council believes it has been effective in presenting the position of the practising physician and in assuring the recognition of the individual physician in the large state programs.

One factor of extreme importance in this connection is the level at which the State of California compensates physicians for their services to state wards. In fields of the aged, the blind, crippled children and vocational rehabilitation it has become apparent that different levels of professional fees are in use. State officers have resisted attempts to increase fees which are considered substandard and have, instead, insisted on "freezing" medical fees at a substandard level for all medical services. The Council is now working on means to "unfreeze" such fees and put them more in line with the going level of professional fees in all parts of the state. This procedure is bound to be lengthy and cumbersome but it is hoped that reasonable standards may be evolved so that physicians treating patients where the State of California is responsible for payment may receive fees in keeping with their normal charges for comparable services.

3. *Governor's Committee on Medical Aid and Health.*

During the entire year the Council has followed the deliberations and subsequent decisions and recommendations of the Governor's Committee for Medical Aid and Health. Doctor Paul D. Foster, C.M.A. president, and Doctor T. Eric Reynolds, immediate past president, have served as members of this committee and have kept the Council advised on its progress. Obviously, a great deal of proposed legislation will result from the findings of this committee; the Council intends to follow such legislative proposals as they are introduced and to take such action as is deemed proper for the public health and the practice of medicine.

A further conference, the White House Conference on the Aging, is scheduled to be held in Washington in January. Several physicians have been included in the list of invitees prepared by Governor Brown; reports may be expected from these participants prior to the Annual Session. Recommendations from California to be presented at this conference are the result of a similar conference held by the governor in Sacramento, at which the two thousand participants declined to approve proposals which would have injected the state further into the practice of medicine.

4. *Bureau of Research and Planning.*

During 1960 the Bureau of Research and Planning continued to expand its library and reference material. Toward the close of the year a director of research was employed and he has already outlined for the consideration of the bureau a number of proposed areas of research. The Council has been kept advised of the activities of the bureau and is confident that under the aegis of the new director a sound program and solid progress may be anticipated.

5. *Relative Value Studies.*

The Council approved the new edition of the Relative Value Studies and copies have been issued to all members. This work has attained a national position and copies are in demand from all parts of the country. The Council is aware of the fact that this study may be misinterpreted and has agreed with the committee which produced the studies to the inclusion of repeated cautions to the effect that this is not a schedule of fees. At the same time, it is obvious that the level of fees in the various areas of California may be related to the Relative Value Studies and that the work may therefore be of extreme value to many members. Plans are currently under consideration for making periodic revisions of these studies as economic conditions change.

6. *Disability Insurance.*

During 1960 the underwriter of the Association's disability insurance program has added a 10 per cent increase in benefits to existing policies and has provided, on an underwriting basis, for double the original coverage purchased by members. The insurance committee has agreed with the underwriters and the administrator that periodic reviews of financial results under this contract shall be made and that premiums will be lowered or benefits increased when and if benefit payments fall below an agreed-upon percentage of premiums received. New members of the Association are eligible to participate in this program and it has been noted that a reasonably large percentage of new members do take advantage of this protection.

7. *Society Security Poll Format.*

The Council in 1960 approved a format for polls which may be taken by county societies on the question of compulsory inclusion of doctors of medicine under the OASDI provisions of the Social Security Act. To date seven county societies have availed themselves of this format and have polled their members on this question. The results of these polls have shown a wide variation as between areas of the state. Additional polls may be taken by several other societies which have requested the format. Meanwhile, the Jenkins-Keogh Bills are still alive in the Congress and the movement to force physicians into the Social Security system continues. No estimate is possible at this time as to the sentiment of physicians in California because of the inconclusive results from various counties.

8. *California Medicine.*

The content of CALIFORNIA MEDICINE has come under review by an ad hoc committee to study all scientific activities of the Association. This committee hopes to have at least a progress report ready for the 1961 House of Delegates. In addition, the Editor has suggested several innovations which the Council has approved. The journal continues to rank high among the state and regional medical publications of the country and under its able editorial leadership the Council is confident that its status will remain highly respected.

9. *Public Relations.*

The Committee on Public Relations has worked throughout the year on the expanded public relations program contemplated last year. The committee has broken down its activities into categories and has named subcommittees for each. In addition, it has set up a subcommittee for motion pictures, television and radio. This subcommittee has reviewed a number of scripts and pilot films for TV viewing and has outlined a projected series of television programs. Most of these would be public service programs and a few would be "spectaculars" which would be sponsored by the Association and would carry messages of socio-economic factors. The Council has followed the activities and progress of this committee and has established special committees to review the financial expenditures of the television film promotions. A new staff member has been employed to bring technical television knowledge to the committee.

The Council wishes to point out that progress in the field of public relations is difficult to measure in an exact manner. The program under development at this time is designed to improve the stature of the profession in the eyes of the public, to leave with the public an impression of the medical profession which is comparable to that of a satisfied individual patient with his individual physician. Much planning and careful preparations are essential in this undertaking. While some members have proposed that teams of professional public relations counsel be employed to secure the desired results, the Council and the committees concerned are confident that the improvement of the image of the medical profession in the eyes of the public must proceed from the inside. This procedure will not show spectacular or immediately measurable results but will gradually improve the public image of the profession and help return it to the enviable position enjoyed by an earlier generation of physicians.

One aspect of public relations which has brought great credit to the profession has been the promotion of campaigns to assure prophylaxis for poliomyelitis and tetanus. Organized drives in selected county areas have made a favorable public impression and have provided the people of those areas with the protection against these diseases which is available from the vaccines we already have. This is preventive medicine in its highest sense. The Council has recently approved a resolution calling for widespread promotion of polio inoculations as a public health measure in which the medical profession can provide essential services and simultaneously afford the greatest possible protection to the public.

10. *Publications Corporation.*

During 1960 the Council approved the formation of a publishing corporation, known as Six Ninety Three Sutter Publications, Inc. This is a wholly-owned subsidiary of the Trustees of the California Medical Association and its business will be the sale of materials produced by the Association. Such publications as the Relative Value Studies, the Industrial Accident Commission fee schedule and others which are in great demand by others will be handled by this corporation. Regular distribution of published material to C.M.A. members will not be affected; however, where other organizations, insurance companies and others wish copies of C.M.A. materials, the publishing company will handle the sales and attempt to recapture a portion of the original production costs. Already there has been a great demand for the new edition of the Relative Value Studies and this is expected to continue. The business of the corporation is handled by the regular staff of the Association; overhead costs will be met by the payment of charges to the C.M.A.

11. *California Physicians' Service.*

Representatives of California Physicians' Service regularly attend meetings of the Council and present progress reports. Three members of the C.P.S. Board of Trustees are appointed each year from among the members of the Council and thus provide a direct and continuing liaison between the two organizations. Where matters of C.P.S. policy are involved, the Council is frequently asked for an expression of judgment for the guidance of the Board of Trustees.

It is obvious that the course of C.P.S. in recent years has been made difficult by conflicts of interest and philosophy, especially among physicians. It is also obvious that many physicians are not familiar with the fact that California Physicians Service was founded by unanimous vote of the C.M.A. House of Delegates and that it is now and has at all times been part and parcel of the C.M.A. The Editor of CALIFORNIA MEDICINE has prepared an editorial to bring out this fact and it is hoped that he will elaborate on the relationship between the two organizations in later issues. The making of policy for C.P.S. originates in the C.M.A. House of Delegates. The function of the Council is to implement and carry out the decisions of the House. It is hoped that the members of the House of Delegates will be fully aware of the blood relationship of C.M.A. and C.P.S. in considering resolutions and policy proposals brought up for discussion.

During the past year there has developed a divergence of opinion between C.P.S. and some of the county societies which have sponsored county-wide programs for the supervision of voluntary health insurance programs. This divergence has been explored to some extent by the Council and it has been voted to ask the appropriate committees of the Association to study the present and the potentially desirable spheres of activity of the various types of underwriters and mechanisms in the field of voluntary health insurance. It is expected that these studies may establish a more clearly defined course which can be recognized and followed by the profession in the years ahead.

12. *Osteopathy.*

During 1960 the Council was advised by the Committee on Other Professions that the continuing discussions with representatives of the California Osteopathic Association had reached a point where specific proposals could be drafted for the consideration of both professional organizations for the unification of the two.

Reports have been made to the Council on the broad outlines of the program tentatively developed by the two organization committees and the Council has approved the continuation of discussions along these lines.

The California Osteopathic Association was confronted with the demand of the American Osteopathic Association to discontinue any discussions with the C.M.A. which might result in the discontinuance of recognition of osteopathy as a profession in California. Leaders of the osteopathic association prepared a series of committee reports on the various aspects of potential unification with medicine and called a special meeting of the C.O.A. House of Delegates to vote on the question of continuing discussions with the C.M.A. on pain of losing the charter issued by the American Osteopathic Association. The C.O.A. House of Delegates voted to continue such discussions and the national charter was subsequently withdrawn.

Prior to the time of the C.M.A. House of Delegates' 1961 meeting, complete details of the proposed plan are expected to be worked out and placed in the hands of all members of the House. A decision must then be reached on the continuation of discussions looking toward unification. If approved by the C.M.A., the same question will again go

before the House of Delegates of the California Osteopathic Association. If approved there, the joint committees, together with others, will then proceed to develop plans for ultimate unification of the two professions in California.

13. *County Officers' Conference.*

At this writing plans are complete for the 1961 Conference of County Society Officers, to be held in Los Angeles in February. Invitations will go to the 1961 presidents, presidents-elect or vice-presidents, and secretaries of all county societies. Also to be invited will be two additional county society representatives who are members of the House of Delegates. In addition, the Commission on Medical Services is inviting the medical service committee chairman and the chairman of the mediation committee of each society to attend this conference. A program under the theme of "The Challenge to the Private Practice of Medicine" has been developed by a special committee of the Council and nationally-known speakers of outstanding ability have accepted invitations to appear. While the subject matter of this conference differs greatly from that of previous county officers' meetings, it is hoped that the leaders of medicine throughout the state may gather first-hand information from this meeting on the points of view of industry, labor, insurance and government on the subject of medical care.

* * *

The items outlined above constitute only a part of the considerations of the Council during the past year. It is hoped that the members of the House of Delegates will review the reports of the commissions and committees in this issue, all of which have come before the Council for consideration.

It is also hoped that all members of the House will feel free to attend the meetings of the reference committee where this report will be reviewed and will bring to those meetings all questions they may have on any item.

Respectfully submitted,

SAMUEL R. SHERMAN, *Chairman*

REPORT OF CALIFORNIA PHYSICIANS' SERVICE

To the President and the House of Delegates:

1960 has been a year of growth and accomplishment for California Physicians' Service. A number of new programs have been placed on the market for the first time. Experimental contracts with new benefit structures have been launched in various areas to develop actuarial experience and test market reactions. A broad new marketing policy has been put into effect. Major increases in membership, income, and claims payments have been achieved.

However, the year has not been without problems, some minor, some substantial, some continuing. But with the help of active and interested medical societies and physicians, C.P.S. has made many notable advances.

Although 1960 has been a year of research and innovation, the future promises to require even more. Public demand for the service concept is ever increasing, and medical science is advancing on all fronts. C.P.S., as our prepayment agency, must advance with it, so that the public may have ready access to the new techniques and case management patterns developed by medical research. It should be emphasized that C.P.S. is our mechanism. It is our responsibility to utilize it to lead the way in prepaid medical care.

It is an able and willing organization and we, of the Board of Trustees, feel that it has served both the public and the profession well during the past year. Some of the highlights of 1960 are noted below:

Physician Participation

During 1960 physician membership in C.P.S. increased substantially, with 14,500 now enrolled as C.P.S. Physician Members. As important as the numerical gain, perhaps, is the increased awareness of the meaning of C.P.S., and its significance to medicine, reflected by the more active support and participation in its affairs by physician members. This cooperation and involvement has been mutually beneficial. It is hoped that it will continue and grow.

Membership Status

At the end of 1960, membership in the commercial programs of California Physicians' Service stood at 971,068 persons. This represents an increase of about 25 per cent over the past year. Much of this increase can be attributed to the new Blue Shield Federal Employee Group Plan, for which C.P.S. handles the professional service coverage in California.

Financial Position

Dues income for the past year exceeded 41.5 million dollars. Claims payments for professional and hospital services rendered C.P.S. members exceeded 35.5 million dollars. In addition, another 18 million dollars in service costs were paid from government funds under programs of various governmental agencies for which C.P.S. serves as fiscal administrator.

Reserve funds at the end of the year totaled approximately 15 million dollars, a figure in line with the recommendations of the National Association of Blue Shield Plans and public regulatory agencies. This represents about four months operating costs.

Claims Handling, Advisory and Review Committee Activities

Medical directors have been discontinued in C.P.S. In their place, county or regional consultants are being appointed, who will be supervised by an over-all coordinator of medical consultants.

County Society Review Committees continued their cooperative aid in handling difficult and involved claims. These impartial committees rendered some 1,400 decisions on fee cases, complicated situations, and cases disputed by the member or physician.

New Benefit Structures

In response to resolutions passed at the 1960 C.M.A. House of Delegates meeting, C.P.S. has developed and placed on the market a number of new benefit variations.

Among these are the *Two-Unit Deductible Outpatient Medical Contracts.* After a trial in San Joaquin County, this program is now available to groups throughout California on a broad spectrum, though still on an experimental basis.

A program for individuals providing outpatient medical services, with a deductible and co-payment hospital feature, has been placed on the market. The plan has been announced to brokers appointed to market Individual Plan programs, and is now available throughout the state.

An experimental program providing hospitalization for diagnostic purposes has been developed and made available. This is the first C.P.S. contract to attempt coverage of this type. Actual experience with this program is being observed very closely with respect to both public acceptance and utilization costs.

In the continuing effort to improve coverage for retired persons and others no longer eligible for group benefits, C.P.S. has developed two new Continued Membership Programs, based on the "B" and "C" Fee Schedules. The old program based on the "A" Schedule is no longer

economically sound and is no longer marketed. The new Continued Membership Programs also provide broadened x-ray and laboratory benefits outside the hospital.

An experimental *Home Nursing Care* program has been developed in collaboration with the Riverside County Medical Society and the Riverside Visiting Nurses Association, and is being made available to Riverside County groups.

Regional Programs

C.P.S. has continued its close cooperation with county medical societies throughout the state who are interested in developing special programs to meet regional needs. Foundation programs provided through C.P.S. are now in operation in San Joaquin, Kern, Fresno, Kings, San Bernardino, Orange, Mariposa, Merced, Tulare, Calaveras, Stanislaus, Tuolumne, Sonoma, Santa Clara, and San Diego counties. Individual programs written in conformance with Foundation wishes and standards have also been introduced in many of these counties. As of December 31, 1960, 11,302 contracts were covered under these various area arrangements.

The C.P.S.-Riverside County Plan based upon the "usual fee" of the area has continued to receive enthusiastic approval. A similar program for individuals has been developed and placed on the market for those ineligible for group membership.

The San Mateo County Medical Society has also adopted the "usual fee" approach and a C.P.S. program incorporating this feature is now in the process of enrollment.

C.M.A.-C.P.S. Liaison Committee

The work of this committee has proved most helpful to the C.P.S. Board of Trustees in implementing C.M.A. policy and the activities called for by the House of Delegates' resolutions. A word of sincere thanks is due to the House of Delegates for its foresight in appointing this committee, as well as to the committee itself for its forthright action during the year.

Federal Employee Health Plan

Enrollment under the new Federal Employee Health Plan was undertaken by the Federal Government in July, 1960. More than 61,000 employees chose the Blue Shield-Blue Cross Program in California. With enrolled dependents, about 180,000 persons are now covered by the plan within the state.

Specifically, out of a total of 545,000 federal employees and their dependents choosing one of the programs in California, 178,000 elected the Blue Cross-Blue Shield service program, 162,000 the indemnity plan, 61,000 employee organization plans, 144,000 one of the group practice and individual practice prepayment plans.

C.P.S. and the two California Blue Cross Plans, who jointly administer the Federal Employee program, spent months preparing authorized descriptive material and developing necessary administrative procedures for the program, which is considered a test case not only of the service concept, but also of the ability of private enterprise to meet the needs of the nation for prepaid health care. For these reasons, the efficient administration of the program in California is one of the major tasks and objectives of C.P.S. The future development of voluntary prepayment will depend to a significant degree upon how well this job is done.

Individual Programs Marketed Through Brokers

In 1960, for the first time, the C.P.S. Individual Family Programs were placed on the market exclusively through brokers and agents. The adoption of this marketing policy for the sale of the individual contracts followed as a logical step the successful marketing of the group contracts through these agencies.

New Trustees

Two new members joined the C.P.S. Board of Trustees during 1960. The newcomers, Herman H. Stone, M.D., Riverside, and William H. Thompson, M.D., San Mateo, are widely known in connection with their C.M.A. activities.

Communications with Medical Societies

In an effort to improve communications with component medical societies, summaries of C.P.S. Board actions are now submitted regularly to society executive secretaries, and items of interest are mailed periodically for use in society bulletins. These are but steps toward the objective we wish to achieve, namely, full two-way communication of significant information. A periodic newsletter, patterned after that of the C.M.A., is in the process of planning.

California Physicians' Insurance Corporation (Indemnity)

During the past year, C.P.I.C., the wholly owned subsidiary of C.P.S., has matured to the point where it operates as a well integrated and diversified health insurance carrier. It has been a year of consolidation, reappraisal and modest growth.

After careful study, C.P.I.C. placed on the market during the past year a number of new programs for the primary purpose of increasing its competitive position without sacrificing its broad objectives.

As of January 1st, 73,168 persons are covered under C.P.I.C.

Respectfully submitted,

JOHN G. MORRISON, *Chairman*
C.P.S. Board of Trustees

REPORTS OF COMMISSIONS

COMMISSION ON CANCER

To the President and the House of Delegates:

This report covers the activities of the Commission on Cancer for the year 1960-61.

There have been two meetings of the commission. The commission, in order to conform with the general organization plan of the C.M.A., has been reorganized with nine members and five committees. There has been no curtailment of established commission activities, but the reorganization and inauguration of new projects consumed considerable time and attention. Activities are summarized in the following categories:

Committee on Cancer Education: The committee met once in 1960-61. Fifteen cancer conferences were conducted during the year for 820 physicians; eleven for county medical societies and four for county chapters of the Academy of General Practice. This represents an increase over the past year. The conferences will be continued and efforts will be made to reach those areas which have not previously been adequately served.

The committee recommends republication of "Cancer Studies," a reference book on cancer for California physicians, last published in 1950. Funds for a portion of this project are included in the proposed budget.

"CA: A Bulletin of Cancer Progress" has been distributed to all physicians requesting the periodical, jointly by the California Medical Association and California Division of

the American Cancer Society. Five thousand copies were distributed every two months.

Committee on Consultative Tumor Boards: Previous full approval of fifty-two Tumor Boards and provisional approval of sixteen was continued. Two provisional approvals were granted during the year. In 1961 the list will be extensively revised and published. The medical director personally surveyed twenty-six tumor boards in 1960.

Committee on New and Unproved Methods of Cancer Treatment: Senate Bill No. 194 is being administered by the Department of Health with advisory assistance from the commission. The first test of the law will occur in 1961.

Committee on Special Cancer Programs: The committee met once in 1960 to maintain liaison with professional and lay groups active in cancer control. An important 1960-project was direction and support in the professional aspects of the mass film showing of "Time and Two Women." The film was shown by the American Cancer Society to approximately 90,000 California women.

Committee on Tumor Tissue Registry: The registry has been very active. Its senior and junior study groups and two annual slide conferences contribute greatly to the accuracy and uniformity of pathological diagnosis, an essential and initial unit of cancer control. The feasibility of adding an audio digest tape to the study sets is being explored.

An article was published in the May 14, 1960 issue of the *Journal of the American Medical Association* (Vol. 173, No. 2), on the high validity of pathological diagnosis of breast cancer in California.

Because of the uniqueness and value of the registry, a history is being prepared.

American Cancer Society, California Division: In addition to the action of the immediately preceding committee, the medical director of the commission, who is also medical director of the cancer society, provided liaison and continuity of cancer control programs. The nine members of the commission who serve on the board of directors of the society provide similar service in policy making.

Joint programs of the two agencies include sponsorship of cancer conferences, distribution of "CA: A Bulletin of Cancer Progress" and support of the Tumor Tissue Registry.

Central Tumor Registry (California Department of Public Health): The Advisory Committee has met once and recommended continuation of the studies of why patients die from cancer of the skin and discontinuation of the registration of benign tumors. This registration was found to be so variable as to be valueless. Mention has been made earlier in this report of the publication of the paper on diagnosis of carcinoma of the breast.

In conclusion, the chairman expresses his appreciation to the members of the commission and committees on cancer for their diligent efforts and support and to the diligence and understanding of the Medical Director Dr. Eugene Miller, without which the progress briefly summarized in this report would not be possible.

Respectfully submitted,

BURT DAVIS, *Chairman*
Commission on Cancer

COMMISSION ON COMMUNITY HEALTH SERVICES

To the President and the House of Delegates:

The resolutions referred to this commission were its main topics of discussion at the meeting held early in 1960. Resolutions were referred to appropriate committees within the commission.

The Committee on Traffic Safety was made a standing committee and part of this commission.

Doctors Ruth Frary of Watsonville, and Francis Redewill, Jr., of Whittier, represented the commission at the Governor's Conference on Children and Youth at Asilomar in the fall.

Recommendations from the committees of the commission on resolutions referred to the various committees were considered by commission members by mail. The recommendations were then made to the Council by the commission chairman. This process has saved commission members time and C.M.A. money in carrying out the affairs of the commission.

Respectfully submitted,

JAMES C. MACLAGGAN, *Chairman*
Commission on Community Health Services

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Committee on Allied Health Agencies

A suggested guide for the county medical society to follow in working with voluntary health agencies was prepared and distributed during 1960. It was suggested that local county medical societies establish a standing committee on allied health agencies.

The committee continues to receive information from the National Information Bureau regarding national voluntary health agencies and maintains a complete and detailed file on the programs of these organizations. This information is available, upon request, to any county medical society having need for such information.

Respectfully submitted,

JAMES C. MACLAGGAN, *Chairman*
Committee on Allied Health Agencies

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Committee on Blood Banks

There has been one meeting of the Committee on Blood Banks since their last report to the House of Delegates. At this meeting the committee reviewed the reports from the blood banks operating in California and found that they all were complying with the standards adopted by the Council in January of 1958. The committee will continue to study the operation of these blood banks.

The committee has approved the format of a certificate to be issued to those blood banks complying with the standards. It is anticipated that these certificates will be ready for distribution to those approved blood banks within the near future and will be issued subsequently on an annual basis.

The members of the Committee on Blood Banks continue to be active members of the California Blood Bank System.

Respectfully submitted,

JAMES MOORE, *Chairman*
Committee on Blood Banks

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Committee on Disaster Medical Care

During 1960, the name of the Committee on Civil Defense and Disaster was changed to the Committee on Disaster Medical Care, and the membership of the committee increased to six members.

Drs. Wayne Chesbro, Frank F. Schade, and Justin J. Stein were reappointed by Governor Edmund P. Brown to the Governor's Emergency Medical Advisory Committee, with Dr. Justin J. Stein as chairman of the committee. This gives direct liaison between the medical profession and the California Disaster Office.

Invaluable training and medical disaster care information was obtained from test-exercises held throughout the state

by local county medical societies. Members of the C.M.A. Committee on Disaster Medical Care were active in all of the test exercises, either as participants or as observers.

The first symposium on Disaster Medical Care was held during the 1960 Annual Session of the California Medical Association. The symposium was well received and attended. Plans have been completed for the second symposium to be held in conjunction with the 1961 Annual Session.

Drs. Robert Range, Wayne Chesbro and Justin J. Stein were given awards of merit for meritorious service to the people of the United States and the medical-health professions in civil defense and disaster medical care at the annual meeting of the United States Civil Defense Council in September, 1960.

Drs. Wayne Chesbro, Frank F. Schade and Justin J. Stein participated in the A.M.A. Conference on Disaster Medical Care, with Dr. Stein acting as conference chairman. Dr. Chesbro was named chairman for the 1961 A.M.A. Conference on Disaster Medical Care, and Dr. Justin J. Stein as program chairman for the medical part of the program of the 1961 Annual Meeting of the United States Civil Defense Council to be held in Los Angeles, October, 1961.

This committee is most fortunate in having all of its members so active and dedicated to the problems associated with disaster medical care. All the members have actively participated in some phase of this problem, either on the local, regional, state or national level.

It is anticipated that a great deal will be accomplished during 1961; also, that more effective support will be given to the county medical societies.

Respectfully submitted,

JUSTIN J. STEIN, *Chairman*
Committee on Disaster Medical Care

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Committee on Industrial Health

During the past year the name of this committee was changed from the Committee on Industrial Health to the Committee on Occupational Health by the Council. This was done to describe more accurately the activities of this committee, which are broader in scope than simply treating injuries and disease from industry. Occupational health refers to the employee's needs, both as an individual and as a worker; and includes the aspects of treatment, accident prevention, occupational disease control, work environment, human relations, rehabilitation, and preventive medicine (health maintenance). The American Medical Association and several State Medical Associations have similarly changed the name of their committees considering these same matters.

The work of the Subcommittee on Standardization of Joint Measurements in Industrial Cases, Packard Thurber, Sr., M.D., chairman, has been completed, and the 1960 edition has been published (Evaluation of Industrial Disability, Oxford University Press). A resume of the changes from the previous edition has appeared in CALIFORNIA MEDICINE. This publication should be of great interest to all those working in the field of industrial medicine.

The committee has several projects under consideration, one of which is the publishing of a series of monthly articles in CALIFORNIA MEDICINE dealing with the problems of occupational health. It is anticipated that this series will have its first article published within the very near future, and may stimulate a question and answer column in the journal as well.

Another project is the development of guidelines for county medical society committees on Occupational Health to assist them in the conduct of their committee activities and to stimulate formation of such committees where needed. In a preliminary survey of county medical societies, there was an indication that such guidelines were desired. It is hoped that these will be available within the near future.

A subcommittee is being established to study the relationship of heart disease to occupational exposure. Edward P. Luongo, M.D., was named chairman of this subcommittee.

During the past year a very close working liaison has been established with the Bureau of Occupational Health of the State Department of Public Health. This liaison has proved to be of great mutual benefit.

During the year, your chairman and the staff coordinator for the committee were privileged to attend the Annual Congress on Industrial Health, and the Joint Conference of Chairmen of State Committees on Industrial Health, held in Charlotte, North Carolina, under the auspices of the American Medical Association. This proved to be a most worthwhile meeting and, among other things, helped to strengthen the liaison between the A.M.A. Council on Occupational Medicine and the Committee on Occupational Health of the C.M.A.

An increase in the committee membership has occurred, due to the increasing activity of your committee.

Inquiries from the A.M.A. Council on Occupational Health, and from other states, have been answered promptly. Advice has been rendered to Riverside County in regard to developing their committee. Liaison has been established with the Committee on Legislation, in an attempt to be of assistance on matters within our field of interest.

Various members of your committee participated in the Fourth Annual Western Industrial Health Conference in San Francisco, October 1960, and are also contributing their efforts to the American Industrial Health Conference in April, 1961, at Los Angeles.

Respectfully submitted,

PACKARD THURBER, JR., *Chairman*
Committee on Occupational Health

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Committee on Rural and Community Health

With the cooperation of the Rural Health Department of the California Farm Bureau Federation, your committee is planning a series of rural health conferences on a regional basis, rather than statewide as in previous years. Plans and topics for the conferences are made by the local representatives of the CFBF with the guidance of your committee. It is felt that this way, the attendees of the conference will hear discussed topics for which they feel a need and not something that is brought in from outside their region.

The medical representatives in each of these conferences are from the regions in which the conferences are held. This gives a closer feeling of cooperation between the medical profession and the conference attendees. Enthusiasm is high and it is expected that these conferences will be well received.

During 1960, a rather comprehensive study of domestic migrant agricultural workers' health needs and living needs was made by the Department of Public Health. The committee reviewed this report with the Committee on State Medical Services. This report and the Council recommendations are included in the annual report of the Committee on State Medical Services.

Respectfully submitted,

ROBB SMITH, *Chairman*
Committee on Community and Rural Health

Committee on School Health

The Committee on School Health has had an active program during 1960. The California Medical Association along with the California Teachers' Association and the State Department of Education co-sponsored a Workshop on Teacher Health which was held on November 17th and 18th. The participants of this workshop are leaders in their particular fields which included school administrators and board members, industrial, private and school physicians and other interested professional groups. The attendance was limited for the purpose of permitting intensive discussion by those persons well acquainted with the subject of teacher health.

As to what use will be made of the deliberations of this workshop and what effect it will have upon future teacher health programs is difficult to determine at this time. There seems to be no question that those who attended felt that the subject was explored in a way which has never been done before and which permitted much greater sharing of different attitudes than would be possible under any other type of approach. At the present time, the Committee on School Health is involved in summarizing the results of this workshop and recommending future activities in the area of teacher health.

Another matter of considerable concern to school health has been the recommendations of the Citizens' Advisory Commission on Education which have related particularly to health education, physical education and driver training. These recommendations were given thorough consideration and the California Medical Association Council was advised of the findings and recommendations of the Committee on School Health.

Another subject which has been a matter of concern to the Committee on School Health is the vision screening programs in California. This interest was stimulated by an extensive study which suggested that there should be significant changes in the screening methods. This problem has been and will be reviewed with considerable close scrutiny since it involves all the children in the public schools in California. At the present time the Committee on School Health does not have any specific recommendations to make on this matter but will be following the various programs with interest during the coming year.

Respectfully submitted,

CHARLES A. BRANTHAVER, *Chairman*
Committee on School Health

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Committee on Traffic Safety

This committee is now a standing committee of the California Medical Association. Being one of the newer committees, it has found many areas where its attention is needed.

House of Delegates Resolution No. 9, calling for first-aid training of ambulance drivers, has been studied by the committee and referred to the Council for implementation.

House of Delegates Resolution No. 54, calling for the assistance of doctors of medicine to the Department of Motor Vehicles in the screening of motor vehicle operator's license applicants who may be subject to seizures causing loss of control of a motor vehicle, was studied by the committee and recommendation made to the Council.

The committee is currently studying a commercial motor vehicle operator's physical examination form.

A campaign to urge members of the organization to purchase and install seat belts in their automobiles is about to be implemented.

The committee enjoys good rapport with the Department of Public Health, with representatives of the Department of Motor Vehicles, and with the California Highway Patrol. It is working very closely with all of these state agencies.

Respectfully submitted,

JOSEPH F. MAGUIRE, *Chairman*
Committee on Traffic Safety

COMMISSION ON MEDICAL EDUCATION

To the President and the House of Delegates:

The Commission on Medical Education has attempted to correlate the continuing education activities of the Association as far as possible.

The commission had one meeting during the past year, at which time it considered the matter of medical scholarships, and recommendations were made to the Council concerning this matter.

Your attention is directed to the reports of the committees serving under the commission, which indicate the wide scope of interest of this commission and its committees.

Respectfully submitted,

ALBERT C. DANIELS, *Chairman*
Commission on Medical Education

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Committee on Maternal and Child Care

The Committee on Maternal and Child Care met twice during the past year.

As in the past, the bulk of the work done by this committee is accomplished by the diligence of our five District Maternal and Mortality committees. These committees meet at periodic intervals to give careful study to the maternal mortality that occurs in their districts. Without the eager cooperation of the district committees, the accomplishments of the Committee on Maternal and Child Care would be rather negligible.

Within the past year case reports have been submitted to the editor of CALIFORNIA MEDICINE for publication. These case reports are actual cases studied by our committee and contain suggested procedures that could have been instituted to prevent the fatality. The committee is of the opinion that these case reports have great educational value.

It is anticipated that the work of this committee will continue, that additional case studies will be made and the results published for the edification of those physicians concerned with obstetrics. By so doing, it is the hope of the committee that the maternal mortality rate will be further decreased. The continuing working relationship with the Bureau of Maternal and Child Health of the California State Department of Public Health makes the activity of the committee possible. We are particularly indebted to Doctors Leslie Corsa and Theodore Montgomery of the Bureau for the assistance they have given the committee.

The Subcommittee on Infant Mortality unfortunately has been able only to have preliminary planning meetings during the year, and has not as yet established the program for studying infant mortality. It is anticipated, however, that this subcommittee will have its program well established within the next few months, now that several "roadblocks" have been eliminated.

A committee of the American Medical Association is also studying infant mortality and our subcommittee is maintaining liaison with this A.M.A. committee.

Respectfully submitted,

JAMES W. RAVENSCROFT, *Chairman*
Committee on Maternal and Child Care

Committee on Postgraduate Activities

During the past year your Committee on Postgraduate Activities has continued the program underway since 1950.

An advisory group of district representatives assists the committee in its postgraduate efforts: E. F. Cain, Anaheim; G. Horace Coshow, Carpinteria; Patrick R. Allanson, Ukiah; Max Dunievitz, Auburn; Robert H. Quillinan, Sacramento; Robert S. Quinn, Santa Rosa; Campbell H. Covington, Selma; and Edwin W. Tucker, Monterey, continue to assist. These physicians have assisted the Postgraduate Activities Committee greatly in stimulating interest in their areas and bringing to our attention special problems and needs. There have been two meetings of the committee together with the district representatives during this period.

Regional Postgraduate Institutes: The committee has conducted five two-day Postgraduate Regional Institutes in five regions of the state, each comprising several county medical societies as follows: Southern counties at Palm Springs; North Coast counties at Santa Rosa; San Joaquin Valley counties at Yosemite; West Coast counties at Pebble Beach; Sacramento Valley counties at Lake Tahoe. The academic program at each institute is planned by one of the five medical schools in the state after consultations with the local regional committee representing the various county medical societies. These institutes offer a continuing interchange of professional experience between medical schools and practicing physicians, companionship and fellowship between colleagues, a combination for professional advancement.

The committee is especially indebted to the five medical school postgraduate directors and their fine faculties for the excellent programs they have fuurnished and to the regional institute chairmen: Robert M. Zweig, Riverside; H. Ward Wick, Santa Rosa; Campbell H. Covington, Selma; Robert H. Helfrich, Salinas; and Herbert W. Korngold, Sacramento.

Circuit Courses, consisting of lectures and conferences, and afternoon clinics in some cases, four in fall and four in spring, were given in the northern part of the state in Eureka, Ukiah, Napa, Dunsmuir, Chico, Marysville and Auburn, by faculty groups from the University of California and Stanford University Schools of Medicine. At the request of Shasta County Society, circuit courses in Redding were added beginning in fall, 1960. We are grateful to Dr. Farber and Dr. Roger Wilson of University of California and Dr. Rantz of Stanford University and their faculty members who arranged and presented the programs. Local chairmen for Circuit Courses are thanked for their continued cooperation. Several resident physicians accompanied instructors from the two schools on the circuit tours, this project supported by the C.M.A. public relations department.

Annual Session Postgraduate Courses: At the request of the Committee on Scientific Work, the Committee on Postgraduate Activities, with the cooperation of the three medical schools of Southern California, again organized postgraduate courses as a part of the scientific program of the California Medical Association annual session in Los Angeles, February 1960.

Motion Picture Program: Under the direction of Dr. Paul D. Foster, chairman of the motion picture division, ten film symposia were presented during the California Medical Association annual session. Attendance at the symposia ranged between 50 and 225, a total of over 1,200 physicians. The panel discussions have proved very popular with physician audiences and time for this portion has been increased. There were 37 discussants including 15 medical school teachers, 19 practicing physicians, two attorneys and one nurse—of these, seven were authors of films shown.

Medical Dates Bulletin, an ever-growing listing of all postgraduate courses and medical meetings in the state has been published by the committee for the past seven years. A grant by Wyeth Laboratories of $8,800, an increase over their grant of $6,000 in 1959, made it possible to publish and mail the listing monthly instead of bi-monthly, to approximately 2,500 organizations and hospitals in the state. In addition, *Medical Dates Bulletin* is mailed twice a year, January and September, to all California Medical Association members and is published monthly in CALIFORNIA MEDICINE.

Survey: A survey of all postgraduate courses and continuation educational meetings in California during 1959-60 was made for the ad hoc Committee on Scientific Activities and Continuing Education. The survey, soon to be published, shows tremendous activity and growth in this field and will be continued over the next 3 to 5 years.

The Committee was represented at the A.M.A. Congress on Medical Education in Chicago in February 1960 and at the Association of American Medical Colleges meeting in Miami in November 1960.

Activities of the committee will continue as in the past until advice is received from the Council for any modifications or changes recommended by the ad hoc Committee on Continuing Education and Scientific Activities.

Respectfully submitted,

ALBERT C. DANIELS, *Chairman*
Committee on Postgraduate Activities

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Committee on Scientific Work

The Committee on Scientific Work has met twice during the report period to discuss with the members of the various sections and others the format of the Annual Scientific Session. During these meetings the speakers for the general sessions were selected and the room assignments for the section meetings made.

At the invitation of Doctor Wilbur, chairman of the ad hoc Committee on Continuing Education and Scientific Activities, the members of the Committee on Scientific Work have met with his committee to discuss matters of mutual concern regarding the future of the C.M.A.'s role in continuing education.

The committee is grateful for the interest and cooperation of those section officers who have been of such assistance to the committee in planning the Annual Scientific Session.

The Committee on Scientific Work has also concerned itself with the scientific exhibits to be shown at the annual meeting. Many applications were reviewed, but because of space limitations only a relatively few could be accepted for showing at the annual meeting. It is the hope of the committee that in the future more space will be made available for the showing of scientific exhibits.

Respectfully submitted,

ALBERT C. DANIELS, *Chairman*
Committee on Scientific Work

COMMISSION ON MEDICAL SERVICES

To the President and the House of Delegates:

The Commission on Medical Services has functioned through its committees and the reports listed below are self-explanatory.

Two of the major programs of the commission this year have been to implement the House of Delegates action regarding the implementation of the usual fee indemnity

concept and to strengthen the mediation committee concept within the county society structures.

The reports of the committees of the commission are listed below.

Respectfully submitted,

DONALD C. HARRINGTON, *Chairman*
Commission on Medical Services

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Committee on Aging

There has been only one meeting of the Committee on Aging during the report period, but individual members of the committee have been most active in participating in federal, state, and local meetings dealing with the problems of the aging.

Unfortunately, your chairman was not able to attend the Governor's Conference on Aging held in October, but several of the committee members were in attendance, as well as other physicians from many parts of the state. Because of the preliminary planning and the pertinent information that was supplied physicians prior to attending the meeting, medicine's voice was well heard and well received by the majority of those attending the conference.

Your chairman was privileged to attend the White House Conference on Aging in January, as an official delegate of the State of California. This was a most rewarding experience and I am happy to report that the physician delegates as well as many other of the California delegates, conducted themselves in such a manner as to make known to the conference in no uncertain terms the wishes and desires of Californians as they pertain to the problems of the aging.

The California Joint Council to Improve the Health Care of the Aged continues to very active and a member of our committee, Doctor Allan E. Voigt, has just started his second year as chairman of the Joint Council.

One of the major activities of the Joint Council during the past year has been to establish an accreditation program for Nursing Homes and Related Facilities. This program is about to get under way. In order to assist the administrators of Nursing Homes and Related Facilities to meet and maintain the standards established for accreditation, it is the opinion of the Joint Council that official liaison should be maintained with county medical societies. Guides to assist county medical societies in this project have been developed and sent to each society for implementation. Each county medical society is urged to participate actively in this program.

Because of the widespread interest in the problems of the aged, it is anticipated that the Committee on Aging will become increasingly active in this field. You may rest assured that the committee, both collectively and individually, will be active not only on your behalf but on the behalf of those aging individuals who need our attention.

Respectfully submitted,

CLARENCE H. ALBAUGH, *Chairman*
Committee on Aging

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Committee on Fees

The Committee on Fees has completed its major assignment with the revision and up-dating of the Relative Value Studies and a more detailed explanation of the committee's work is contained in the preface of the 1960 Revised Edition which has been sent to every member of the Association.

The committee is presently undertaking a pilot study of the relationship between the gross income and the costs of practice in the four categories listed in the Relative Value Studies—Medicine, Surgery, Radiology, and Laboratory.

The Committee on Fees is also working jointly with committees of C.P.S. in reviewing various schedules and assisting C.P.S. in revising and/or devising new schedules.

Respectfully submitted,

H. DEAN HOSKINS, *Chairman*
Committee on Fees

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Committee on Government Financed Medical Care

During the past year, this committee has kept in close contact with California Physicians' Service representatives who are acting as fiscal agents for the Veterans' Administration Hometown Care Program, the Department of Defense Medicare Program, and the various public assistance medical care programs of the State Department of Social Welfare.

In general, the Medicare and VA Hometown Care programs have been operating with a minimum of difficulty. Representatives of both the Department of Defense and the VA have advised that the administration of the program by the fiscal agent in California and the participation by California physicians has been excellent.

We have presented the 1960 Relative Value Study to both departments and requested that they seriously consider adopting the nomenclature and relativity set forth in the 1960 Relative Value Study. It is expected that in the year ahead these two programs will continue at approximately the same level they have maintained during the past year.

This committee, together with the Liaison Committee to the State Department of Social Welfare, has actively studied the implementation of the Mills-Kerr Bill by the California Department of Social Welfare. This program has been more completely discussed in the report of the Liaison Committee to the State Department of Social Welfare.

It is expected that during the coming year, both this committee and the Liaison Committee to the State Department of Social Welfare will closely follow the implementation of the Public Assistance Medical Care Program, the development of the Medical Assistance to the Aged Program and the research pilot study that is being conducted in connection with the health evaluation physical examinations.

I want to gratefully acknowledge the unselfish work of the committee members, Doctors A. E. Berman, Thomas Elmendorf, Ferrall Moore, William Quinn, Cyril Attwood, J. Lafe Ludwig, Samuel R. Sherman, Malcolm Todd, Donald Abbott, John Morrison, William Todd and John E. Vaughan.

Respectfully submitted,

JOHN M. RUMSEY, *Chairman*
Government Financed Medical Care

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Liaison Committee to the California Vocational Rehabilitation Service

This committee was appointed this year. It has held two meetings. The general purpose of this committee is:

(a) To be informed about the medical aspects of the Federal Old-Age Survivors' Disability Insurance (OASDI) program,

(b) To establish liaison with the California Vocational Rehabilitation Service since by contract with the Department of Health, Education and Welfare that Service is the administrative and investigative agency which reviews all applications under the program, and

(c) To develop a system to better educate the physicians in the medical processing of the program and reduce misunderstandings relative to it.

During the meetings to date, the committee has studied the background and provisions of the OASDI program and has met with representatives from the Vocational Rehabilitation Service to hear from them about the day-to-day operation of the program.

It is proposed that during the coming year a series of educational articles be prepared and distributed to the profession.

I am most grateful to Doctors Elliot Rouff, Elizabeth Austin, Mandel Sherman and William Todd for their fine assistance.

Respectfully submitted,

FRANCIS J. COX, *Chairman*
Liaison Committee to the California Vocational Rehabilitation Service

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Liaison Committee to the State Department of Social Welfare

Since the last annual session, this committee has met three times to discuss the development of a public assistance medical care program in California. Two members of this committee are appointees on the Advisory Committee to the State Department of Social Welfare. One member of this committee, Doctor Samuel R. Sherman, was selected by the members of the Advisory Committee to be their chairman.

During the past year, the Congress passed the Mills-Kerr Bill, which amended the Social Security law to provide additional money to purchase further medical care for the aged. As a result of this legislation, it will be possible for California to increase the medical benefits for Old-Age Security (OAS) recipients substantially.

Advice concerning the additional medical care to be provided was sought of this committee and ad hoc advisory committees in specialized fields. The program now provides for eye care and glasses, and also for dental care. Early in 1961, the program will provide for elective office surgery and outpatient radiotherapy. Inpatient rehabilitation services will be provided for OAS recipients recommended by their personal physician in certain approved rehabilitation facilities. Approval of the facilities is based upon standards developed by the State Department of Public Health and an ad hoc committee. These standards were adopted by the State Social Welfare Board.

A health evaluation physical examination will be made available to all OAS recipients between the ages of 65 and 70 when they are certified to the program during a one-year pilot study. An ad hoc committee composed of internists and general practitioners developed a special report form to be used by physicians to report the results of these physical examinations. Space is provided for a narrative type of report with suggestions for treatment, prognosis, and additional comments where indicated, such as one might expect from a consultation by an internist where a $28.00 fee is paid. The special report form permits the information obtained to be easily and uniformly tabulated. The Department of Social Welfare has made application for a special research grant to enable it to study and report findings obtained by this one-year pilot study.

The House of Delegates passed a resolution at its last session recommending that the OAS drug program be expanded. With the availability of additional funds and after careful study by a Drug Advisory Committee, both the Liaison Committee and the Medical Care Advisory Committee have recommended to the department that the drug program be expanded.

The Mills-Kerr Bill provides matching federal funds to assist states in developing a program to provide medical assistance to the aged (MAA) who are not OAS recipients and who but for extensive medical expense would be able to maintain themselves on their available resources. This program cannot be implemented without enabling state legislation.

The Council adopted this committee's recommendation that California Physicians' Service (C.P.S.) investigate and report the possibility of underwriting the Medical Assistance to the Aged program on a prepaid basis, or handling it as a fiscal agent as is done for dependents of servicemen under the Medicare program.

This committee has kept the profession informed about these many developments through letters to county officers, articles in *Newsletter* and articles in CALIFORNIA MEDICINE. This committee has been very active during the past year in reviewing the development of programs for the State Department of Social Welfare and for C.M.A. members.

I am very much indebted to Doctors Samuel Sherman, John Rumsey, John Morrison and Thomas Elmendorf for their untiring efforts and fine spirit of cooperation.

Respectfully submitted,

WILLIAM F. QUINN, *Chairman*
Liaison Committee to the State Department of Social Welfare

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Committee on Medical Care Insurance

In the reorganization of the Commission on Medical Services, it was decided to establish a new standing committee within the Association that would deal specifically with medical care insurance programs. An appropriate by-law provision will be discussed by the Council to accomplish this.

The committee has established a number of subcommittees each of which will deal with a specific phase of the insurance movement.

Reports of these subcommittees are included as a part of this committee.

Respectfully submitted,

DONALD C. HARRINGTON, *Chairman*
Committee on Medical Care Insurance

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Subcommittee on Local Medical Society-Sponsored Programs

In 1959 the Commission on Medical Services established a Subcommittee on Foundations for Medical Care. The purpose of that Subcommittee was to serve as a central source of information from which any county society could obtain information on this type of program. In 1960 the name of this Subcommittee was changed to the Committee on Local Medical Society-Sponsored Programs.

Since there is now a greater variety of such programs in existence in California, Foundations for Medical Care have now been organized in 21 counties.* These Foundations have voluntarily grouped themselves into what is known as the Federation of Foundations for the purpose of making available Foundation-approved programs to the federal employees.

Other programs sponsored under the auspices of a county medical society include the usual fee concept, as typified by the program of the Riverside County Medical Association. All of these county society-sponsored programs encompass similar concepts such as local determination of fees and local control and processing of claims.

While not sponsored by a county medical society, the program of the Douglas Aircraft Corporation in Los Angeles was developed in cooperation with several of the district branches of that county society. The so-called San Fernando Valley Physicians Plan is also one which has the cooperation of local physicians.

*Calaveras, Fresno, Imperial, Kern, Kings, Lake, Madera, Marin, Mariposa, Mendocino, Merced, Orange, Riverside, San Bernardino, San Diego, San Joaquin, Santa Clara, Sonoma, Stanislaus, Tulare, and Tuolumne.

The committee still continues to serve as a fact-finding body and information is available to any county medical society. The committee makes no recommendations regarding these plans.

Respectfully submitted,

JOHN F. MURRAY, *Chairman*
Subcommittee on Local Medical Society-Sponsored Programs

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Subcommittee on Miscellaneous Programs

The Committee on Miscellaneous Programs was established by the Commission on Medical Services to serve as a fact-finding body to develop information on programs within the state which do not utilize normal insurance criteria and which could be called unclassified and miscellaneous programs.

Outlined below are the various types of programs which the committee is beginning to study. All of these programs are used in some fashion in conjunction with the prepayment of medical care.

Consumer-Sponsored Medical Center Plans. This type of plan is lay-sponsored and is organized with the facilities provided by an employer or cooperative. The policy-making decisions, with respect to administration and financing and in many instances medical care provisions, are not controlled by physicians. Usually in this type of arrangement, the physicians are paid on a salary or a capitation basis. Examples of this would be the Community Health Association of Hoopa, California; San Diego Health Association and French Benefit Societies of Los Angeles and San Francisco. These plans are commonly called closed panel plans and are not open to all physicians nor the public. These plans are self-limiting as to source of patients and limit the diagnosis and/or treatment provisions according to the facilities and staff available. In many instances, they are composed of a medical director with part-time physicians.

Doctor-Sponsored. This type of plan is organized as an individual proprietaryship, partnership or corporation by physicians who provide their own facilities and retain control over the administrative and financial aspects as well as the medical aspects. Examples of this would be Ross-Loos and Bay Medical Group of San Francisco.

Company-Sponsored. Under this arrangement, a company or employer maintains clinic facilities and employs physicians on a whole or part-time basis on either a flat salary or hourly wage. Examples of this type of plan would be the Pacific Electric Railway; Southern Pacific Railway; Santa Fe and the Metropolitan Transit Authority of Los Angeles and the Health Service System of San Francisco.

Union-Sponsored. This type of program is sponsored and controlled entirely by a union. The union owns the facilities, controls the management and financial arrangement and pays the physicians on either a salary or hourly basis. Usually the facilities and treatment are limited and not open to the public and many part-time physicians are used. Examples would be the International Lady Garment Workers Health Center in Los Angeles and the Health Center of the San Francisco Central Labor Council.

Open Panel Plan. This type of plan allows the consumer groups or their members to go to any licensed doctor but has special arrangements with certain doctors who in turn accept certain fee schedules as full payment for the full services rendered. In this arrangement, the employer or union controls only the financial aspects of the program. Examples of this are the Union Oil Company in Los Angeles; District Number 1578, International Association of Machinists; Retail Clerks Local Number 1442; Norse-Thermador Company; Packard-Bell Corporation; Pacific Mutual Life Insurance Company; Associated Tidewater Oil Company and various transportation companies and/or unions have this type of arrangement in Southern California.

Open Control Panels. These are panels of physicians that, in theory, are open to all licensed physicians that meet certain qualifications but that actually are limited or closed in most respects. Essentially they are established in such a manner that substantial reasons, mostly financial, are created that will steer most of the members of a group to the panel physicians. Payments are made to the participating doctors in agreement with a certain allowance as full payment. If a member goes to a nonparticipating or nonpanel doctor, he must pay the bill himself. In Southern California, examples of this could be cited as follows: Furniture Workers Local 123; The California Medical Center Plan; The Western Businessmen's Association in Norwalk.

Closed Panel Plan. These are programs under which the member has no benefits unless he goes to the contracting doctors or clinics. In some cases, there are payments provided for out-of-area coverage and for emergencies. Examples of this in Southern California are the Pacific Health Plan; the National Health Plan; California Health Association; Southern California Health Association; Osteopathic Physicians and Surgeons Medical Plan; Physicians and Surgeons Association and the Community Prepaid Medical Services, Inc.

Joint Sponsored Plans. This type of plan is usually cosponsored by both labor and management using health and welfare funds to contract directly with medical groups and private practice. Examples of this type of plan are the MacDougal Medical Group in Long Beach; Ray E. Harris, M.D., and Associates of San Francisco. Other examples could be cited such as the Retail Clerks in Santa Monica and Gardena contract with four medical groups; industry in the San Fernando Valley contract with two medical groups.

Respectfully submitted,

HENRY GIBBONS, III, *Chairman*
Subcommittee on Miscellaneous Programs

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Subcommittee on Uniform Claim Forms

The Subcommittee on Uniform Claim Forms has, over the past year, devised a claim form which it considers to have merit and which could possibly be adopted by the Association for use statewide by physicians in reporting claims for their patients covered by indemnity insurance. The Health Insurance Council has been working on a similar project and has proposed a different form for adoption on a national basis.

The subcommittee has conducted pilot studies in five counties. In San Diego, Fresno and Ventura counties studies have been conducted with the claim form designed by this subcommittee. In Marin, Napa and Ventura counties pilot studies have been conducted with the form developed by the Health Insurance Council.

At the time of the writing of this report, the results of the pilot studies are being compiled and studied. Specific recommendations will be made to the Commission on Medical Services and to the Council before the meeting of the House of Delegates.

Respectfully submitted,

DUDLEY M. COBB, JR., *Chairman*
Subcommittee on Uniform Claim Forms

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Liaison Committee to the California Self-Insurers Association

Several months ago, at the suggestion of the California Self-Insurers Association, a Liaison Committee consisting

of Doctors Elmer Gooel, Albert G. Miller and Milo A. Youel was designated to meet at periodic intervals with that Association.

The initial approach of this committee has been to establish individual contacts with our counterparts from the California Self-Insurers Association.

No meetings have been held at the time of the writing of this report; however, the California Self-Insurers Association is well aware of our interest and willingness to discuss mutual problems at any time.

Respectfully submitted,

ALBERT G. MILLER, *Chairman*
Liaison Committee to the California Self-Insurers Association

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Liaison Committee to the Insurance Industry

The Commission on Medical Services has referred to this Liaison Committee three House of Delegates resolutions from the 1960 House of Delegates.

Resolution No. 47 dealing with the early payment of premiums has been considered by the committee and it is the committee's opinion that substituting the word "state" for national, as stated in the resolution, the resolution can be better implemented in California. The committee has contacted the Health Insurance Association and the Health Insurance Council and will discuss this resolution in more detail with the California Committee to the Health Insurance Council at subsequent meetings.

Resolution No. 48, Insurance Mediation Committees—The committee has appointed a subcommittee to adopt a modus operandi for county society mediation committees. A great deal of work has been done to stimulate a closer look at the functioning of these committees through the Medical Executives Conference and the Commission on Medical Services. A report on the standardized format will be made very shortly.

Resolution No. 65, Code of Insurance Standards—The committee is collecting data of examples of types of standards adopted by various county and state medical societies and will discuss this resolution with the California Committee to the Health Insurance Council.

At the present time, the committee cannot report in more detail regarding the implementing of the intent of the resolutions.

An Insurance Seminar is being planned in conjunction with the industry for this year to discuss mutual problems.

JOSEPH TELFORD, *Chairman*
Liaison Committee to the Insurance Industry

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Committee on Rehabilitation

The survey conducted by the Committee on Rehabilitation to ascertain physician opinion concerning the problems of rehabilitation has been completed and a final report has been submitted to the Council through the Commission on Medical Services. It is hoped that this report will receive wide distribution, as it is felt that it contains a great deal of valuable information.

It was quite evident from the survey that physicians desire more information concerning the rehabilitation problems, and especially they desire information as to the location of rehabilitation facilities and the criteria for admission to these facilities. There were indications also that it would be helpful for the Committee on Rehabilitation to intensify their activities in the field of professional education, and the committee is now giving this serious consideration.

Several members of your committee, including the chairman, served as individuals, not as members of the committee, on an Advisory Committee to the State Department of Public Health to establish criteria for rehabilitation facilities, that would be utilized by the Department of Social Welfare in their expanded medical care program for OAS recipients. These standards have been adopted and are now in operation.

The committee has considered proposed federal and state legislation dealing with rehabilitation and transmitted their opinions to the Commission on Medical Services.

The Committees on Rehabilitation of the county medical societies are conducting programs of varying intensity. Some are most active, but most are quite inactive. The committee urges each of the county medical societies to become active and offers to the county medical societies any assistance they can give in the problems encountered at the local level.

Respectfully submitted,

ELIZABETH AUSTIN, *Chairman*
Committee on Rehabilitation

COMMISSION ON PROFESSIONAL WELFARE

To the President and the House of Delegates:

During the past year, the members of the commission were kept advised of the activities of the committees under its supervision by written reports. It has not been necessary for the commission to hold a formal meeting.

Respectfully submitted,

ARTHUR A. KIRCHNER, *Chairman*
Commission on Professional Welfare

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Committee on Health and Accident Insurance

The House of Delegates has, on several occasions, encouraged this committee to extend disability benefits to members of the Association who are over 70 years of age. During the past year, the committee was very happy to report to the members of the Association that Lumbermen's Mutual Casualty, the underwriter for our disability insurance program, on June 1, 1960, agreed to allow insured members the opportunity of renewing their policies beyond the age of 70, at reduced benefits, provided they are actively engaged in their profession and are members of the C.M.A. The benefits are reduced by 50 per cent.

Also during the past year, a 10 per cent bonus effective December 1, 1959, was declared. Effective June 1, 1960, the monthly benefits available were increased from $400 to $800.

The committee has continued to review the disputed cases submitted to the company by our members. Annual reports are also made by the company to the committee of the loss experience. It is the hope of the committee that in the near future it may be possible due to the favorable loss experience of this program, to declare an annual dividend for those insured under the program.

I am indebted to Doctors Arthur Kirchner, Robert Westcott, T. W. Loring and George Herzog for their cooperation and hard work as members of this committee.

Respectfully submitted,

HOMER C. PHEASANT, *Chairman*
Committee on Health and Accident Insurance

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Committee on the Private Practice of Medicine by Medical School Faculty Members

In reporting the findings of the Committee on the Private Practice of Medicine by Medical School Faculty Members, several items of interest may be set forth along with the recommendations of the committee.

1. It is the firm general impression of the committee that the relationship between the administrative officers and faculties of the medical schools and the physicians carrying on private practice in the areas adjacent to these schools has shown a gratifyingly improved spirit of mutual understanding and cooperation. Where individual instances of misunderstanding have occurred during the past year, the difficulties have been largely clarified and resolved via conferences between county medical society liaison committees or individual physicians, and the medical school faculties. It is felt that the recommendations of the Wilbur Committee of 1957 have been cooperatively acted on in a mutually helpful manner to the advantage of all concerned.

2. In the area of publicity the committee again feels that there has developed understanding and cooperation. One writer for the press has commented that the medical schools in his area have "fallen over backwards" to observe compliance with this committee's previous recommendations.

3. In the matter of medical school faculty member's cost of private practice, where such practice is carried on within the medical school itself, it is our observation that such cost records and accounting are, where possible, satisfactorily maintained and that the costs are properly apportioned and borne by the practicing faculty members.

4. It has further been observed that the number of private cases seen by medical school faculty members who are on a geographic full time basis are relatively and surprisingly few.

In conclusion it is the opinion of the committee:

1. That the recommendations of the committee as originally outlined by the Wilbur Report of April 1957 should continue to stand as written at this time.

2. That when new medical schools are effected, the county medical society or societies in the areas adjacent to such new schools, immediately appoint liaison committees to work with the administration of the new schools, to bring about understanding and cooperation between the practicing profession of the area and the medical school faculty, as well as to aid development by all possible means the highest standards obtainable within the school, in scientific as well as student development.

3. That present liaison committees continue their obviously effective efforts and that all complaints be first submitted to the county liaison committee, for evaluation and recommendation.

4. That medical schools maintain meticulous care in follow up data to physicians in regard to referred cases—as to findings—recommendations and, where indicated, discussion of cost. By so doing much good will may be generated in case handling.

5. That as it is the medical profession's aim to preserve the private practice of medicine as well as the highest standards of medical education it would behoove our purpose to endorse a larger segment of private practice patients within the medical schools. That the degree of increase of private practice allowed faculty members be adjudicated by the medical school administration.

To the end that:

a. It would emphasize to the student the advantages of the individualized care of the patient in private practice.

b. It would preserve the private practice atmosphere and individualism in the mind of the medical school faculty member and his transmission of this to the student.

c. It would help place on a more realistic and comparatively equitable basis the medical school faculty member's income with that of the individual in the practicing profession at large.

d. It would gain for the medical school a better case load of teaching material, which latter is becoming a pressing need, due the present effect of prepaid medical care.

e. And lastly, it will not be forgotten that those engaged in the private practice of medicine have an obligation to perpetuate and support, in medical teaching and progress, that to which their own success has been attributable.

Respectfully submitted,

WERNER F. HOYT, *Chairman*
Committee on the Private Practice of Medicine
by Medical School Faculty Members

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Medical Review and Advisory Board

Since the last meeting of the House of Delegates, the Medical Review and Advisory Board has held two meetings with representatives from the California Hospital Association committee interested in medical-legal problems. These two committees have undertaken to prepare papers on several topics that are important to the medical profession. After the articles have been reviewed, they will be made available to the profession. The articles will cover such matters as tissue committee activities, a medical staff by-law requirement concerning staff members carrying adequate professional liability insurance; malpractice insurance for medical staff activities, recommended procedures for needle count, medication errors and identification problems, etc.

An educational article was approved by the committee and published in CALIFORNIA MEDICINE advising the profession about current trends in malpractice cases. Several articles have been published during the year in CALIFORNIA MEDICINE and in other bulletins which were sponsored by the legal counsel of C.M.A. and the Medical Review and Advisory Board.

Representatives of the M.R.A.B. took part in a two-day hospital medical-legal institute presented under the auspices of the California Hospital Association. The program included topics concerning joint hospital-physician liability problems. The institute was very well attended, with representatives from nearly all the major hospitals in the state.

During the coming year, the M.R.A.B. will assist the A.M.A. in conducting a regional conference on medical-legal problems in San Francisco.

The untiring work of the members of the committee, Doctors Kaiser, Powell, Webb, Yant, Adelstein, Burtness, Ginsburg, Ross, Moore, Quinn and Rees is gratefully acknowledged.

Respectfully submitted,

ARTHUR A. KIRCHNER, *Chairman*
Medical Review and Advisory Board

COMMISSION ON PUBLIC AGENCIES

To the President and the House of Delegates:

The Commission on Public Agencies has maintained close contact with its committees throughout the past year and has reviewed all recommendations made by committees under this commission prior to their submission to the Council.

The commission has been fortunate in that most of its deliberations have been conducted by telephone or mail ballot. Consequently, it has not been necessary to hold formal meetings of the commission. Nevertheless, it remains active and its members follow closely all programs developed by committees constituting the commission.

The reports of the various committees will speak for themselves.

Respectfully submitted,

OMER W. WHEELER, *Chairman*
Commission on Public Agencies

Committee on Adoptions

During the past year, the Committee on Adoptions had printed and sent to the members of our association, copies of a Manual of Adoptions for Physicians. Over 25,000 copies of this manual have been distributed to interested persons. The daily press of the state commented most favorably on this effort of C.M.A. to help stamp out the black market in babies.

The committee has followed with interest, two legal actions involving California physicians during the past year. A New York indictment involved two California physicians and others, charging a violation of the New York adoption law. Recently, one California physician has been indicted by a county grand jury of this state, along with several lawyers.

The Manual of Adoptions for Physicians points out that the function of the physician is to act as a confidant of the natural mother providing both medical care and social advice and to report on the physical and mental status of all parties concerned in an adoption proceeding if he is called upon to do so. Frequently, an obstetrician, pediatrician and family physician may all be involved in one or more stages of an adoption proceeding.

It has been pointed out that it is improper and unethical for a physician to function other than as a physician or to coerce any of the parties involved to follow one adoption proceeding rather than another.

The committee has studied several federal legislative proposals that were introduced into recent sessions of the Congress concerning the interstate placement of children for adoption.

During the coming year, it is anticipated that the committee will be called upon by county medical societies and others to consult and study adoption problems that may arise.

Doctors McNeil, McNulty, Walsh, Degenhardt, Fenlon, Beckh, Mapes and Tieche have been most cooperative and helpful in the deliberations of this committee.

Respectfully submitted,

GEORGE K. HERZOG, JR., *Chairman*
Committee on Adoptions

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Committee on Mental Health

During the past year, the committee has been concerned with numerous problems, one of the most pressing of which has been the place of hypnosis in medicine. The committee has heartily endorsed the 1960 House of Delegates Resolution No. 37 wherein the Association opposes the use of hypnosis for entertainment purposes. The committee has recommended to the Council that appropriate measures be taken, if possible, to prohibit the use of hypnosis for such purposes. Numerous questions dealing with this general subject have been discussed and in response to a request from the Office of Dependents Medical Care, the committee recommended to the Council that hypnosis be considered an adjunctive agent in the practice of medicine and merely a component of therapy, not a separate or individual method of treatment. An article will soon appear in CALIFORNIA MEDICINE which will describe in detail the shortcomings and possible side effects of hypnosis and the need for further study on this subject.

The committee, in cooperation with the Western Interstate Council on Higher Education, is cooperating in a pilot program in the Sacramento area, aimed at familiarizing more physicians with the facts about psychiatry. The committee continues to hold periodic meetings with the California Psychological Association and hopes, in due time, to reach agreement with that organization on the relative roles of psychologists and psychiatrists in the field of mental health.

A closer working relationship is being developed with the Northern, Central and Southern California Psychiatric Societies to ensure a close cooperative functioning of these organizations with the state and county medical associations.

The committee continues its liaison with the State Department of Mental Hygiene and wishes to compliment Doctor Daniel Blain, director of that department, for his forthright and positive approach to the role of this state agency in the field of mental health.

Representatives of the committee have attended the National Conferences on Mental Health sponsored by the American Medical Association and we look forward to continuing California's representation at these meetings.

The committee in cooperation with California Physicians' Service is developing a program of insurance coverage for short periods of in-patient psychiatric care in accredited hospitals or accredited sanitariums. This new venture in the health insurance field will be tried on a pilot basis by C.P.S.

Our field is a challenging one. We like working with the problems involved. We hope that the results justify our efforts and your confidence in us.

Respectfully submitted,

STUART C. KNOX, *Chairman*
Committee on Mental Health

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Committee on Other Professions

During the current year, the Committee on Other Professions has met on one or more occasions, with representatives of the California State Nurses' Association, the California Pharmaceutical Association, and the California Osteopathic Association. Liaison has been maintained with the State Board of Nurses' Examiners by virtue of representation of two members of the committee on the Advisory Committee to the State Board of Nurses' Examiners. As directed in the Resolution No. 53, passed by the last meeting of the House of Delegates, the committee has conducted a survey of Hospital Nursing Training Schools in California and the results of this survey together with recommendations of the committee are incorporated in a separate report to be made available to each delegate.

During the year, a number of meetings were held with representatives of the California Osteopathic Association in an attempt to reach an agreement between the California Medical Association and the California Osteopathic Association to effect a merger of these two professions. An understanding has been reached which, it is felt, will be of mutual benefit to the public and to the professions involved. This agreement has the approval of the Council of the California Medical Association, and the corresponding governing body of the California Osteopathic Association, and will come before the House of Delegates of both organizations for consideration. A part of the solution of this proposed merger of the professions involves the conversion of the Los Angeles College of Osteopathic Physicians and Surgeons to an approved Medical School. The deans of the three medical schools in Southern California have been of invaluable assistance in attempting to reach a practical solution of the many aspects of the problems relating to the college. The Committee on Other Professions feels this proposed agreement provides a suitable solution to a complex problem of long standing and recommends its acceptance by the House of Delegates.

Respectfully submitted,

WAYNE POLLOCK, *Chairman*
Committee on Other Professions

Committee of State Medical Services

The Committee of State Medical Services meets jointly with the Director of the State Department of Public Health and selected members of his staff. These meetings have become of increasing importance both to organized medicine and the State Health Department because of the ever-increasing responsibilities imposed by legislative acts and the rapid advance of medical science.

The State Committee of Medical Services has conferred with the Department of Public Health in matters dealing with air pollution, radiation control, insecticides, Tb and polio control, health problems of agricultural workers, hospital and rehabilitation center standards, alcohol and drug rehabilitation, national health survey and many other subjects of mutual interest to the department and organized medicine.

Our committee has recommended and the Council has approved the following:

1. A more aggressive polio vaccination program.

2. The establishment of a new committee on dangerous drugs.

3. A liaison committee between the State Pharmaceutical Association and the California Medical Association.

Dr. Malcolm Merrill, the State Director of Public Health, and your chairman of the Committee of State Medical Services have endeavored through monthly reports to keep the California Medical Association Council fully informed of all our activities.

Respectfully submitted,

OMER W. WHEELER, *Chairman*
Committee of State Medical Services

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Committee on Veterans' Affairs

Excellent rapport has been established with and is being maintained with veterans' groups such as the American Legion, Veterans of Foreign Wars, and Disabled American Veterans.

The committee is currently studying Veterans' Administration hospitals and the non-service connected admissions to these institutions. The committee continues to hold as its objectives the representation of the profession to those in the medical service of government and to the veterans' service organizations and to learn from government and veteran service organizations what it expects of medicine.

The committee continues to urge members of the medical professions to become more interested in the activities of the government in medical fields and local, state and national levels. And, for those persons who can, to join organizations available to them to represent medicine well.

Respectfully submitted,

CHARLES B. HUDSON, *Chairman*
Committee on Veterans' Affairs

COMMISSION ON PUBLIC POLICY

To the President and the House of Delegates:

The Commission on Public Policy has concerned itself during the past year primarily with coordination of legislative activities and public relations activities. The commission has reviewed at the request of the Council several matters and made appropriate recommendations to the Council. The reports of the committees serving under the commission are noted below.

Respectfully submitted,

DAN O. KILROY, *Chairman*
Commission on Public Policy

Committee on Legislation

Your Committee on Legislation has been active during the year 1960 primarily with interim sessions of committees in both houses of the legislature and with various campaigns in both the primary and general election.

A supplemental report will be rendered at the 1961 House of Delegates meeting of the California Medical Association.

Respectfully submitted,

DAN O. KILROY, *Chairman*
Committee on Legislation

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Committee on Public Relations

The Committee on Public Relations is privileged to report a year of substantial progress and accomplishment. The rate of progress and the degree of accomplishment has been necessarily and properly limited by the requirements of the democratic process which governs this association and within which its committees operate and by the organizational and administrative problems inherent in a major effort of this magnitude. The committee has met regularly and reported to the Council which has approved its actions. It has had the full support and cooperation of the C.M.A. staff.

Broad Review of Three-Year Program

In 1958 the Council approved a broad three-year public relations program which will be completed by July 1961.

In the first year the objectives were to increase understanding among physicians of the factors underlying present problems in medical care, to emphasize that good public relations is good performance which is understood and appreciated and to establish the principle that what is best for the patient is always best for the doctor and the medical profession. Public relations therefore must always be expressed in terms of patient and public interest and not in terms of doctor interest, and be backed up by a record of performance.

In the second year the traditional doctor-patient relationship received greater emphasis. It was defined by the committee and identified as a critical element which must be present in the best medical care and which is absent in undesirable forms of collective medicine. The committee sought to extend its principles to relationship between organized medicine and the community or the public. It emphasized that the traditional methods of diagnosis, treatment, prevention and rehabilitation are as applicable to the socio-economic and political ills of medical care as to the ills of the flesh. The committee called attention to the vast number of meaningful contacts between medicine and the public, in doctors' offices, in hospitals, on telephone, radio, television and in the press, and recognized the enormous public relations influence of these built-in mass communications mechanisms of medicine. The principles of the doctor-patient relationship were equated with good public relations for medicine at all levels and it became clear that medicine's public relations program must therefore be "grass roots" and emphasize the role and activities of the physician and his staff as PR agents as well as of the local medical society in the community.

The objectives of the third year, 1960-61, were to clarify the role of medicine in the socio-economic and political evolution of our culture with relation to the concepts of freedom and security particularly as they relate to medical care and the welfare of the individual, and to emphasize that it is the public, the voter, who will decide the future of medical practice. Based on the foregoing, a position and dynamic program of public relations was to be undertaken.

Some Special Characteristics of Medicine's Public Relations

Medicine's public relations differs from advertising a product or from that of a business or industry. Everyone instinctively dislikes having to have medical care, yet there is a widespread interest, almost a preoccupation, with anything pertaining to medicine. This means that efforts at promotion or selling are often resented, yet public service or educational activities get widespread attention and publicity and at comparatively little cost. Fortunately these can be expressions of the doctor's interest in his patient and of organized medicine's interest in the community and in the public. Thus medicine's PR must be "grass roots" best medical care and public service, and, as in diagnosis and treatment, its position on socio-economic and political matters must be based upon a determination of the facts, sound decisions or policies expressed in the patient's interest, and demonstrated action or performance. Also public relations must utilize medicine's built-in mass communications mechanisms as well as more conventional mass communications media.

The Accelerated PR Program for 1960-61

The action of the 1960 House of Delegates which authorized an increase in C.M.A. dues of ten dollars per member to be added to the public relations budget enabled the Public Relations Committee and the Public Relations Department to undertake an accelerated program. The total program has been under the direction of the committee and its actions have been approved by the Council.

An initial step was to request of county and district component societies and of individual members their suggestions for the C.M.A. accelerated PR program. Some hundreds were received. These were compiled, and together with suggestions from the C.M.A. staff were rated in importance by the committee. They became the basic material upon which the program is built. A large number of excellent suggestions were necessarily set aside because of limitations in budget and personnel. It was decided that for the first year of the accelerated program the major emphasis would be given to television programs, public service programs at the county society level, pamphlets and brochures, and the development of new PR programs and projects for use at county and state level.

The following basic principles were agreed upon:

1. The primary aim of the public relations program is to create a public image of the physician and organized medicine which will be such that the public will listen to organized medicine in the same way a satisfied patient listens to his doctor.

2. In general, the socio-economic messages of organized medicine are better presented through others until such time as No. 1 is achieved. It is understood that a maximum effort will be made to develop this indirect approach initially at C.M.A. level.

A Subcommittee on Television, Radio, and Motion Pictures under the chairmanship of Dr. John Schaupp was appointed by the Council and directed to produce a series of 26 half-hour programs, entitled "Doctors at Work." Studies have shown that approximately 70 per cent of people form impressions of, say, a business or industry, from television. Other mass communications media are considerably less effective. The "Doctors at Work" series as developed by the subcommittee provides an ideal device to emphasize the doctor-patient relationship, to demonstrate the personalized services rendered by doctors to patients to show the complexity of medical practice and modern medical care, and to identify the county and state medical association with the favorable image of the individual physician working for his individual patient. The subcommittee was directed to include emphasis on socio-economic factors to the point of public and station tolerance as recommended by its TV consultants. In addition five educational programs on socio-economic subjects were approved for inclusion in the series. Larry Williams and staff of San Francisco and Jerry Pettis of Los Angeles were retained as TV consultants. The public acceptance of this series is not known at the time this report is submitted.

A Subcommittee on County Society Programs, under the chairmanship of Dr. Douglas Donath was appointed by the Council and directed to encourage and assist county public relations programs primarily directed toward maintaining and improving a favorable public image of the physician and organized medicine. The initial goal for this year has been to achieve the activation of two or three new programs in each county society—or approximately 100 new programs throughout the state. The programs recommended for this purpose have been tried somewhere in the state and are known to be effective. The PR staff has developed materials to assist the county societies with these new projects. It is anticipated that the proliferation of these programs will have important impact.

The Public Relations Committee has divided itself into four project development subcommittees to develop further (1) the socio-economic facet of the PR program, (2) liaison with and support of other groups which have common interests with medicine, (3) pamphlets, brochures and publicity for professional and public audiences and (4) projects and programs related to students in schools, colleges and medical schools. It is anticipated that projects developed by these subcommittees and approved by the Public Relations Committee will be activated at the state level or recommended to county societies with appropriate material through the Subcommittee on County Society Programs.

C.M.A. staff members have been assigned liaison responsibilities with specific county societies which are geographically contiguous and these individuals work closely with the Subcommittee on County Society Programs and with the PR department. Mr. Bill Tobitt has been added to the PR staff with special responsibilities to the Subcommittee on Radio, Television and Motion Pictures and for news releases and pamphlet preparations. Mr. Murray Klutch has joined the staff for the Bureau of Research and Planning and will be available to the Public Relations Committee. Mr. Clancy and Mr. Marvin have devoted full time to PR activities.

Pamphlets, brochures and circulars continue to be an important part of the C.M.A. PR program. "The Best Medical Care for Every Individual—A Public Relations Challenge" was prepared to provide the profession with a definition of PR goals and how they may be achieved. It was widely distributed and well received. Over a million tetanus circulars were ordered by physicians for distribution to the public, 550,000 Forand Bill circulars were printed to fill physicians' orders in cooperation with the Public Health League. A recent pamphlet "About the Cost of Medical Care" is being accorded widespread acceptance by the profession and the public. Other brochures and pamphlets are under development at the time of this report.

News releases from C.M.A. have been accelerated and press cooperation in reporting medical advances and bringing medical service programs to the public has generally been excellent. Each month an article from CALIFORNIA MEDICINE has been summarized and presented as a press release from C.M.A. There has been noteworthy cooperation by the press with many society programs for the prevention of polio and tetanus.

Effective communications with the membership continue to be a major concern of the PR program. This is necessary if the members are to be effective PR agents. "Newsletter"

has been published monthly and is widely read. The president or president-elect have met with each county society and the councilors have recognized the importance of their role in communications with the membership. Special issues of "Newsletter" devoted to socio-economic subjects were authorized by the committee and are in development at the time of this report.

The Governor's Conference on Aging provided valuable experience in public relations at the sociological level. It was demonstrated that individual physicians, armed with the facts, with a firm organizational policy expressed in the patient and public interest and with a record of performance in support of a sound policy, can exercise an enormous influence on group opinion and group action. Prior to the conference the public relations committee urged that the Council adopt a clear statement of policy on aging. This was done and the background facts were prepared by C.M.A. staff. The record of performance was epitomized in the successful A.M.A. support of the Mills Bill. The result was that none of the 50 sections of the Governor's conference came out in support of the social security approach to medical care for the aged. This experience demonstrated the principles—facts, policy and performance—which must always underlie the successful PR exploitation of C.M.A. activities in the socio-economic field. The doctor-patient relationship was a reality at this conference. The principles of diagnosis and treatment were applied. Also some of the most effective presentations of medicine's arguments were made by others outside the profession.

The committee continued its support of county society programs directed toward medical students, interns and residents in San Francisco and Los Angeles. It is working closely with the Santa Clara and San Mateo societies to develop a comparable program centered on the new Stanford Medical Center in Palo Alto. At the collegiate level materials prepared by the A.M.A. for the national collegiate debating topic for 1960-61, "Resolved: That the United States should adopt a program of compulsory health insurance for all citizens" were distributed personally by physicians to colleges in the state. In several areas well informed physicians discussed this topic with the debaters. It is anticipated that other programs directed toward students in high school and college will soon be developed. These are the voters of tomorrow. Also they are the pool from which future doctors must come.

The Woman's Auxiliary, at the state and county level, have continued to render outstanding assistance in nurse recruitment, nursing scholarships, aid to medical education, meals-on-wheels projects, etc. Several auxiliaries have reviewed "Honour a Physician" for various women's groups. This book, written by an English general practitioner, emphasizes the inadequacies of the socialized medicine system and particularly the breakdown in the physician-patient relationships. The committee is fully aware of the power of these women and their effectiveness in public relations.

Finances—1960-61

The committee found that the funds available for the 1960-61 program were appropriate in amount. The committee exercised its best judgment in their use and believes that the profession will receive a satisfactory return on their investment in public relations for this year. All expenditures, not of an administrative nature, were approved and authorized by a "watch-dog" committee and the chairman of the Public Relations Committee. This proved a most satisfactory arrangement. A meaningful report of the 1960-61 PR budget expenditures is not possible at the time of this report but will be available to the Reference Committees and to the House of Delegates at the 1961 meeting.

Finally, the chairman requests the privilege of presenting a supplemental report to the House of Delegates at the annual meeting and of submitting the following at a later date as appendages to this report:

1. A report on the television series "Doctors at Work."
2. A report on county society programs.
3. A report on the 1960-61 PR budget.

Respectfully submitted,

MALCOLM S. M. WATTS, *Chairman*
Committee on Public Relations

JUDICIAL COMMISSION

To the President and the House of Delegates:

The Judicial Commission has been called upon to review only one disciplinary case in the past year. This case has been completed, the county judicial council ruling upheld and no appeal taken by the member to the Judicial Council of the American Medical Association.

Unfortunately, a great deal of time is required in advance of a hearing of a county judicial council decision. It is essential that the members of the Judicial Commission review the transcript of the county society hearing in order to familiarize themselves with the case. This can be done much more expeditiously if the county societies will advise the central office that disciplinary hearings are to be held. In this way the Association may be able to secure additional copies of the transcript and thus speed up the review procedure.

Respectfully submitted,

DONALD A. CHARNOCK, *Chairman*
Judicial Commission

REPORTS OF OTHER COMMITTEES

BUREAU OF RESEARCH AND PLANNING

To the President and the House of Delegates:

In presenting the annual report of the Bureau of Research and Planning it is timely that a somewhat comprehensive outline be submitted in relation to:

I. The origin and formation of the bureau.
II. Its place within the organization structure of C.M.A.
III. Its purpose and responsibilities.
IV. A summary of its actions to date.

I. *Origin:*

At the annual meeting of the House of Delegates in April 1958 a resolution was passed directing the Council to expedite the creation and establishment of a department of Research and Planning. In July of 1958 the Council implemented this mandate by appointing an ad hoc committee to review the matter and present specific recommendations to the Council. This ad hoc committee met in July of 1958 in Palo Alto. Its report was submitted to the Council and in March of 1959 the Council made appointments officially establishing the Bureau of Research and Planning. Following this, the first organizational meeting of the bureau was held in Los Angeles on March 13, 1959.

II. *The Bureau's Place Within the Organizational Structure of C.M.A.:*

The ad hoc committee recommended:

(a) That the bureau should be integrated within the C.M.A. administrative structure.

(b) That the bureau be answerable to the Council.

(c) That its members be appointed for a period of five years instead of the usual three years because of the complexity and scope of the problems involved in its areas of study.

(d) That research requests of other commissions or committees be forwarded to the bureau who in turn will decide

priority. Findings should not be published other than with the clearance of the Council.

III. *Purposes and Responsibilities:*

The ad hoc committee recommended:

(a) That the basic economic objective was the preservation of private practice of medicine.

(b) That a library adequate to research needs be established under direction of a competent librarian.

(c) That a full-time research director of adequate background and orientation be found to assist in organizing an overall research program for the Association and to implement this program as directed. The ad hoc committee further recommended to the Council that:

1. The primary function would be to determine types in order of priority of research projects in relation to its contribution to public welfare, importance to C.M.A., benefit to C.M.A. members, length of time required, and cost.

2. To recommend to the appropriate commission or the Council when a specific research or planning project should be discontinued.

3. To develop an annual Research and Planning budget in cooperation with the Director of Research and Director of Commissions and Committees.

4. To review and recommend to the Council for approval or disapproval all research reports before release to any source.

5. Develop and initiate long range plans and programs.

6. Research findings would be forwarded to the originating commission and the Council.

7. In case of conflicting research requests in terms of time, cost, personnel and other factors, the final priority determination should be referred to the Council.

IV. *Summary of Actions:*

With this background data the activity and work of the bureau to date may be outlined.

The first regular meeting of the bureau was called by the chairman, Dr. Francis E. West in Los Angeles on March 13, 1959. Following meetings of the bureau during 1959 covered organizational efforts needed to implement the directions of the ad hoc committee adopted by the Council.

A graduate librarian of excellent background, Miss Jean Chadwick, was asked to organize material essential to the bureau's research and study. Miss Chadwick under direction of the Director of Commissions and Committees has accomplished this major step in the bureau's behalf and the library is now filling its proper function in the work of the commissions, committees, Council and the bureau. Further work accomplished during 1959 covered many hours of discussion as to the bureau's orientation in the wide scope of its assignment in the entire socio-economic field and in which lie the problems faced by medicine in its need to adapt to change. Priority of study areas both of acute need and for long range planning were reviewed. Some of the study areas considered were adaptable to research techniques and some others were based on judgment in policy, maturity, medical experience and philosophy.

The bureau has discussed the areas listed below in order to determine specific research projects and priorities.

1. *The Insurance Mechanism:*

Study of the origin and development of voluntary health insurance; concepts and philosophies underlying approaches by medicine, management, labor, government, and other groups within the community. Analysis of various problem areas such as remuneration, extent of coverage and quality of medical care; review of mechanisms designed to meet increasing demands and costs of medical care; examination of form and organization of medical practice as they relate to the prepayment mechanism.

2. *Education:*

(a) *Personnel:* Study of the role of all medical and paramedical personnel in the growing complex of medical care; their training, education and supply in relationship to expanded horizons of care.

(b) *Curriculum:* Review of teaching methods and courses as they have evolved, and should be modified, to equip all medical personnel for their roles in the constellation of medical care.

(c) *Health Education:* Study of the variety of techniques through which health education, including mental; physical fitness, environmental, etc., may be dispersed to all levels of the community, utilizing the training and experience of medical personnel.

3. *Organization and Distribution of Medical Services:*

Study of all facets relating to supply and forms of medical practice, including facilities utilized; new concepts and philosophies to deal with problems of the future.

4. *Communication:*

Study of the methods and techniques to communicate with the public and profession regarding their respective obligations and responsibilities in the attainment of good health. Development of new approaches to create a better atmosphere of understanding.

5. *Historical, Philosophical and Sociological Concepts:*

Study of the diverse forces and philosophies impinging upon, and often motivating or compelling, the development of medical practice; changing concepts of social welfare, government interest, labor-management relationships and professional responsibilities.

6. *Membership Relations:*

Study of all aspects of relationships between physicians in practice and their organizational structure; analysis of needs expressed by each and development of levels of uniform approaches to problems of community concern. Study of membership characteristics to enable intensive study of attitudes towards various problems and issues of medical care.

7. *Labor:*

Analysis of labor's philosophy and demands as they affect all aspects of the socio-economics of medical care.

8. *Rehabilitation:*

Study of the roles of restoration and rehabilitation in the spectrum of medical care; contributions of physicians and paramedical personnel; facilities utilized and required, and creation of public understanding of the outer limits of application.

9. *Quality of Medical Care:*

Study of criteria for determining levels and standards of medical care; methods of evaluating care provided by physicians in various forms of medical practice and assuring provision of good medical care to the public.

10. *Political Implications:*

Study of profession's attitude toward, and relationships to government proposals and direct interest in medical care. Development of broad policy to relate to individual legislators and administrative agencies.

11. *State Study Bureaus:*

Examination of feasibility of expanding research efforts to all constituent associations, promoting cooperative re-

search and stimulating more widespread interest in the values of objective research as an instrument in developing a cohesive, uniform and realistic approach to problems.

12. *Preventive Medicine:*

Study of the role of physicians, the application of preventive medicine in their practice and the promotion of more effective methods to identify professional interest with public concern.

During early 1960 the Council requested that the Bureau of Research and Planning study and recommend guide lines of philosophy and principles which C.M.A. can support as to:

(a) What medical services are the proper responsibility of government;

(b) By which level of government (federal, state, county, or city) should these services be provided;

(c) For which classes of citizens they should be provided.

This study was carried out by Drs. Powell, Davis, and Morrison. Their report was discussed and approved by the bureau and submitted to the Council.

Later meetings during the year in coordination with C.M.A. staff have consummated the establishment of a research department under a director of research, Mr. Murray Klutch, who in December 1960, became a member of the C.M.A. staff. Mr. Klutch has already prepared a program of objectives adaptable to research techniques and their possible means of accomplishment. His entire program will be reviewed and coordinated with study areas already outlined, during January 1961.

The bureau has now developed a research policy and a course of action. During the past two-year period, a reference library has been established in the San Francisco office of the Association under the direction of a professional librarian. It is the only such library in the West.

At the time the bureau was formed, there was no other single organization or agency, governmental or private, sponsoring research of any magnitude or directed at seeking factual unbiased information which would help the C.M.A. reach sound conclusions and develop constructive farsighted policies. Although neither the Association nor the bureau had a clearly delineated research policy, the House of Delegates indicated that adequate financing would be made available. The House also indicated a desire in developing a program in the public and professional interest. Essentially, four approaches to carrying out research have been evolved. They are:

1. Projects to be carried out under the supervision of the bureau and conducted by the staff.
2. Cooperative research with other organizations or agencies, with publication of the findings obtained.
3. Securing research grants for selected studies to be under the direction of the bureau but to be done in part by an outside agency.
4. Projects which students working on doctoral theses can undertake with a minimum of financial assistance from the bureau.

The methods described above offer flexibility of operation and require only a small staff within the department of research. The research proposals which the bureau has recommended are those which can be done on a short term basis of six months to two years duration. Long term projects are also under consideration. Many of the objectives of medicine can be implemented through the research staff by having them serve as consultants to other organizations in their research efforts.

In order for the work of the bureau and its research efforts to be accepted by persons outside the profession, it is important that our efforts be made known, that our methodology and interpretation of data be made public and that the results of our efforts be made available to interested parties.

A research advisory committee composed of research technicians will be established to secure advice and guidance on methodology and survey techniques.

The bureau budget which will be proposed will reflect the necessary growth within the research department and the cost of conducting medical-economic research. The California Medical Association is the first state medical organization to embark upon this type of project.

In planning for 1961 the bureau will direct its effort towards a number of goals:

1. Establish direction and priority of research projects under guidance of the director of research—this in relation to the request of the Council—Commissions and committees and the work of the bureau itself.
2. Attempt to effect a closer liaison with its own work and the work of other commissions and committees.
3. Develop emphasis on study of the insurance mechanism because of the urgency and inclusiveness of content in this vital study area.
4. Regularly bring to its meetings, men of talent, who may point out pertinent data to study areas under consideration.

The bureau wishes to express its appreciation to the House of Delegates for its confidence in, and support of, the efforts being made to carry out the objectives of the medical profession in California.

Respectfully submitted,

WERNER F. HOYT, *Chairman*
T. ERIC REYNOLDS, *Vice-Chairman*
GERALD W. SHAW, *Secretary*
BURT L. DAVIS
PAUL D. FOSTER
JAMES POWELL
DONALD C. HARRINGTON
FRANCIS J. COX
ARLO A. MORRISON
LYLE CRAIG
Bureau of Research and Planning

CHAIRMAN OF THE CALIFORNIA DELEGATION TO THE A.M.A.

To the President and the House of Delegates:

The two meetings in 1960 were attended by practically 100 per cent of our delegates and 100 per cent of our alternates. California still has representative doctors on practically all of the major councils and committees and standing committees of the American Medical Association and as in the past they have been doing a yeoman job of constructive work. Your delegates met each morning for breakfast and discussed the business of the day. They attended the meetings of the House of Delegates, the meetings of the Reference Committees and the California Hospitality Group entertained continuously at lunch throughout the convention.

The New York Delegation was especially anxious to entertain California Delegates but this was also true of the Acey Deucy Group, that is the group made up of those delegates from states who have not more than two delegates.

Dr. Askey, as president of the American Medical Association, made a statesmanlike speech which will be printed in the *Journal of the American Medical Association.*

Dr. James Doyle of California served on the Reference Committee on the Board of Trustees Reports.

Dr. R. Stanley Kneeshaw of California served on the Credentials Committee.

Dr. Leopold Fraser of Oakland, California, was Chairman of the Important Reference Committee on Public Health and Occupational Health.

Your chairman, Dr. Cass, served on the Reference Committee on Insurance and Medical Service.

Dr. Dwight Wilbur of California served on the Reference Committee on Medical Education in Hospitals.

Dr. Joseph Failing of the Section on Anesthesiology, also from California, was on the Reference Committee on Sections and Section Work.

Both the June and December meetings were very successful in accomplishing a great deal in the matter of establishing policy and in December a considerable amount of discussion was held over the impact of the National Elections on the future of medicine. This will all be explained in the American Medical Association and in our report of our Public Relations Department.

At the end of the session your delegates elected Dr. Dwight Wilbur of San Francisco as the new chairman of the delegation and Dr. Donald Charnock of Los Angeles as the vice-chairman.

It has been a pleasure to have served as chairman of this group for several years and I am sure that California will be able to maintain its present position of prestige in the House of Delegates of the A.M.A. under the leadership of Dr. Wilbur and Dr. Charnock.

Respectfully submitted,

DONALD CASS, *Chairman*
Delegates to the A.M.A.

COMMITTEE ON HISTORY AND OBITUARIES

To the President and the House of Delegates:

Since the last annual report, 154 obituaries of departed fellow practitioners were published in CALIFORNIA MEDICINE during 1960. Of this number 29 had passed away late in 1959.

Perusal of the long list of deceased reveals the names of many teachers, prominent leaders in the various specialties and others high in their particular fields of medicine who will be missed by their confrères. Probably the widest recognition goes to Robert T. Legge, known to many University of California students as University Physician on the Berkeley campus for many years.

Respectfully submitted,

J. MARION READ, *Chairman*
Committee on History and Obituaries

FINANCE COMMITTEE

To the President and the House of Delegates:

The Finance Committee is actually a committee of the Council and as such reports to that body. However, its functions are so intimately tied in with the activities of the Association that the committee wishes to make this report to the House of Delegates.

On a succeeding page of this issue will be found the statements of assets and liabilities and of operating results for the fiscal year ended June 30, 1960, for the Association, the Trustees of the California Medical Association and Physicians' Benevolence Fund, Inc. These are prepared from the reports of John F. Forbes & Company, certified public accountants. These subsidiary corporations operate under the supervision of the Council and the members it names as a board of directors or board of trustees for the corporations. In addition, Audio-Digest Foundation and Pacific Magnetic Tape Equipment Co. are wholly-owned subsidiaries.

During the fiscal year reviewed in the printed reports the Association moved into its present quarters at 693 Sutter Street, San Francisco. This involved the occupancy of considerably more floor area than had been available in the former location and also involved the purchase of a sizable amount of furniture and equipment. These purchases are reflected in the cost items shown in the Association's operating statement. The rental figures on this statement will remain at the level shown or will advance as the Association occupies more space in the building. The equipment costs are, for the main part, a nonrecurring item. The budget for the coming fiscal year will reflect a sharp decrease in this category.

As reported a year ago, the committee asked the auditors to review the membership and bookkeeping procedures in use by the Association. Since that report was made, the auditors' report has been received and reviewed by the committee. It was found that the basic procedures in use were adequate and efficient for our operation. Several suggestions for reducing the work load and for simplification of bookkeeping methods were suggested and have been put into effect. In addition, some new equipment will be purchased as a means of meeting the ever-growing needs in the membership records work. This equipment will provide for our needs for several years in advance and will be suitable for further expansion as the membership growth warrants.

The committee has held several meetings during the year and has reported to the Council on all items referred to it by the Council and on other items of its own origin. Reports made to the Council have been published in the Council minutes.

During the past year the committee has investigated the possibility of establishing a retirement program for employees of the Association. Retirement plans are so universally a part of employment today that the committee has recommended that such a plan be instituted in the C.M.A. At present the Trustees carry life insurance policies on several key employees. While this coverage is good as far as it goes, it is costly and it does not operate with justice to all employees or to those not now covered.

An extension of the present plan was reviewed and submitted to outside experts, who were of the opinion that a more equitable and less costly plan could be developed through the use of group retirement annuities and group life insurance. Proposals for this type of coverage are under study and, with Council approval, will be instituted in 1961. Interestingly, the cost of this program will be less than that of the current program, the number of employees covered will be greater and the benefits to employees will be greater.

The committee has also approved the formation of a subsidiary corporation which would serve as a sales agency for some of the publications of the Association. Publications such as the Relative Value Studies and the fee schedule of the Industrial Accident Commission have heretofore been distributed widely at the expense of the C.M.A. The new corporation would permit the sale of such publications as a means of recovering some of their cost. At the same time, as an activity of a subsidiary company, such sales would not jeopardize the professional association status of the Association.

One member of the committee, Doctor Byron L. Gifford of Santa Barbara, resigned during the year for health reasons. He has been succeeded by Doctor J. Norman O'Neill of Los Angeles. The other members of the committee, in whose behalf this report is submitted, are Doctors Paul D. Foster, Ralph C. Teall, Burt L. Davis and the chairman.

Respectfully submitted,

IVAN C. HERON, *Chairman*
Finance Committee

CALIFORNIA MEDICAL ASSOCIATION

Statement of Net Assets, June 30, 1960

ASSETS:		
Cash		$161,298.18
Accounts receivable, net		29,737.34
Loans receivable	$124,744.00	
Less reserve	124,744.00	
Loans receivable, net		
Note receivable—Trustees of the California Medical Association		270,000.00
Furniture and fixtures (at nominal value)		1.00
Prepaid insurance		2,017.50
Other prepaid expense and deferred charges		4,995.66
Deposits		973.10
TOTAL ASSETS		$469,022.78
LIABILITIES AND DEFERRED INCOME:		
Accounts payable:		
American Medical Education Foundation	$162,505.00	
Other	60,822.06	
TOTAL		$223,327.06
Deferred income		7,562.10
TOTAL LIABILITIES AND DEFERRED INCOME		$230,889.16
NET ASSETS		$238,133.62

Statement of Income, Expenditures, and Net Assets for the Years Ended June 30, 1960 and 1959

	YEAR ENDED JUNE 30	
	1960	1959
INCOME:		
Dues and general:		
Membership dues less portion allocated to CALIFORNIA MEDICINE subscription	$840,266.25	$732,057.77
Postgraduate institute	12,445.00	19,111.00
Fee for collection of American Medical Association dues	4,140.25	3,946.51
Interest earned	4,597.80	5,413.26
Other	23.46	20.93
Total	$861,472.76	$760,549.47
Official journal—CALIFORNIA MEDICINE:		
Advertising	$234,007.44	$191,216.39
Nonmember subscriptions	2,300.11	2,193.00
Reprints, net	737.76	646.21
Total	$237,045.31	$194,055.60
Less expenditures (Schedule 1)	235,146.25	216,900.10
Direct (*cost*) gain	$ 1,899.06	*$ 22,844.50*
Allocated portion of members' dues	52,780.50	50,646.00
Total	$ 54,679.56	$ 27,801.50
TOTAL INCOME	$916,152.32	$788,350.97
EXPENDITURES (Schedule 1):		
Administration	$383,428.22	$279,115.21
Scientific, educational, and public relations	552,778.43	558,564.38
TOTAL EXPENDITURES	$936,206.65	$837,679.59
EXCESS OF EXPENDITURES OVER INCOME—CURRENT YEAR	$ 20,054.33	$ 49,328.62
OTHER CREDITS, NET:		
Reduction in reserves on account of:		
Payment on loans	$ 16,876.00	$ 32,923.50
Loan sold to Trustees		55,000.00
Total	$ 16,876.00	$ 87,923.50
Less expenses applicable to prior years, net	890.95	2,028.06
OTHER CREDITS, NET	$ 15,985.05	$ 85,895.44
NET ASSETS:		
INCREASE *(Decrease)*—CURRENT YEAR	*$ 4,069.28*	$ 36,566.82
AT BEGINNING OF YEAR	242,202.90	205,636.08
AT END OF YEAR	$238,133.62	$242,202.90

Italic figures denote decrease.

CALIFORNIA MEDICAL ASSOCIATION

Schedule 1

Statement of Expenditures for the Years Ended June 30, 1960 and 1959

	YEAR ENDED JUNE 30	
	1960	1959
ADMINISTRATION:		
Salaries:		
Executive	$ 48,726.32	$ 46,024.96
Clerical	51,440.39	38,240.05
Total	$100,166.71	$ 84,265.01
Office expenses:		
Rent	$ 15,942.18	$ 9,991.56
Equipment purchases and maintenance	39,101.07	4,689.28
Supplies	11,968.59	7,991.44
Telephone and telegraph	8,507.71	5,333.67
Postage	3,877.62	2,266.78
Professional fees (other than legal)	3,485.00	1,240.00
Moving	1,981.72	.....
Sundry	2,340.13	1,848.12
Los Angeles (other than salaries)	4,085.85	5,546.29
Total	$ 91,289.87	$ 38,907.14
Legal	$ 35,588.32	$ 32,902.29
Meeting expense:		
Annual session	$ 43,421.60	$ 42,693.39
American Medical Association	44,078.21	39,919.46
Student assistance—A.M.A.	1,307.36	3,652.65
Council	8,187.54	8,684.22
Medical executives	9,006.43	8,381.53
County officers	9,551.17	4,208.29
Finance and judicial	1,393.82	.....
Total	$116,946.13	$107,539.54
Less annual session exhibitors' and postgraduate fees	35,675.00	39,995.00
Meeting expense, net	$ 81,271.13	$ 67,544.54
Travel expense:		
Council	$ 19,816.24	$ 17,371.60
Officers	13,278.47	7,336.66
Administrative	4,439.69	3,453.84
Total	$ 37,534.40	$ 28,162.10
Other expense:		
The Woman's Auxiliary	$ 6,252.69	$ 7,484.69
Payroll taxes	6,680.59	4,384.89
Personal property taxes	1,104.74	549.49
Dues and subscriptions	3,743.50	3,035.00
Insurance	4,421.27	3,253.03
California Physicians' Service	6,154.18	4,931.09
Placement	7,801.68	2,425.31
Interest and sundry	1,419.14	1,270.63
Total	$ 37,577.79	$ 27,334.13
TOTAL	$383,428.22	$279,115.21
SCIENTIFIC, EDUCATIONAL, AND PUBLIC RELATIONS:		
Medical services	$ 50,494.69	$ 70,234.78
Community health services	17,360.56	.....
Cancer Commission	34,880.33	33,861.70
Public health and public agencies	13,121.78	13,191.24
Medical education	59,506.85	63,906.69
Professional welfare	23,271.69	40,556.92
Bureau of Research and Planning	18,500.05	.....
Public policy and public relations	130,947.37	142,186.43
Special committees	14,134.91	10,772.25
Contributions:		
American Medical Education Foundation	162,505.00	156,561.50
Physicians' Benevolence Fund, Inc.	16,703.50	16,195.25
Medical Libraries	8,351.70	8,097.62
Nursing League	3,000.00	3,000.00
TOTAL	$552,778.43	$558,564.38
OFFICIAL JOURNAL—CALIFORNIA MEDICINE:		
Printing	$165,213.39	$152,090.26
Salaries	30,372.06	26,793.33
Advertising sales expense (including applicable salaries)	15,954.54	14,932.81
Rent	3,400.54	3,638.28
Telephone and telegraph	2,383.02	1,797.08
Postage and mailing	7,594.58	7,081.61
Addressograph	3,056.39	3,023.90
Illustrations	1,627.59	2,618.21
Advertising cash discounts	4,069.64	3,385.20
Sundry	1,474.50	1,539.42
TOTAL	$235,146.25	$216,900.10

PHYSICIANS' BENEVOLENCE FUND, INC.

(A Nonprofit Corporation)

Statement of Net Assets, June 30, 1960

ASSETS:		
Cash—Crocker-Anglo National Bank		$ 28,411.90
Investments:		
U. S. Treasury bonds, 2½% (at maturity values):		
Due December 15, 1969	$10,000.00	
Due December 15, 1972	34,000.00	
Total (market value, $37,200)	$44,000.00	
U. S. Treasury bills, $50,000.00 face value, due November, 1960 (at cost)	49,153.50	
Total investments		93,153.50
Accrued interest receivable		323.39
TOTAL ASSETS		$121,888.79
CONSISTING OF:		
Contributed assets	$92,132.28	
Excess of income over expenditures	29,756.51	
TOTAL		$121,888.79

Statement of Income and Expenditures for the Year Ended June 30, 1960

INCOME:		
Contributions received:		
California Medical Association (see note)	$16,703.50	
"The Woman's Auxiliary" of the California Medical Association	2,765.64	$19,469.14
Contribution returned by beneficiary		300.00
Interest earned:		
On U. S. Treasury securities	$ 2,371.71	
On loan	500.00	2,871.71
TOTAL		$22,640.85
EXPENDITURES:		
Payments to beneficiaries	$15,925.00	
Other	327.26	
TOTAL		16,252.26
EXCESS OF INCOME OVER EXPENDITURES:		
CURRENT YEAR		$ 6,388.59
AT BEGINNING OF YEAR		23,367.92
AT END OF YEAR		$29,756.51

NOTE 1: The constitution of the California Medical Association, Article IV, Section 6, was amended in May, 1956, and provides: "At least $1.00 out of the annual dues paid by each active member of the Association shall be allocated to the Physicians' Benevolence Fund, Inc., a corporation, and shall be used for the purposes as set forth in that corporation's Articles and Bylaws."

NOTE 2: Subsequent to June 30, 1960, the Physicians' Benevolence Fund, Inc., completed a loan to the Los Angeles County Physicians Aid Association in the amount of $50,000.00 as evidenced by a promissory note dated June 22, 1960. This note is payable in quarterly installments of $1,000.00 plus interest at the rate of 2½ per cent per annum, beginning September 1, 1961, and is secured by a deed of trust on Los Angeles County real estate.

(Continued on next page)

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

(A Nonprofit Corporation)

Statement of Net Assets, June 30, 1960

ASSETS:		
Cash		$ 26,018.97
United States Treasury bonds (at maturity value—market value, $971,480)		1,121,000.00
Contract and note receivable		48,000.00
Accrued interest and rent receivable		2,876.46
Investment—Pacific Magnetic Tape Equipment Co. (Note 1)		9,000.00
Property—At cost (subject to mortgage):		
Land	$ 87,400.00	
Buildings and improvements	295,938.03	
Total	$383,338.03	
Less accumulated depreciation	9,409.00	
Net depreciated value		373,929.03
Cash surrender value of life insurance policies held in trust for California Medical Association employees		101,148.99
Prepaid real estate taxes (contra)		8,500.00
Prepaid insurance		1,073.04
TOTAL ASSETS		$1,691,546.49
LIABILITIES:		
Note payable		$ 270,000.00
Mortgage payable		96,524.52
Trust Fund for California Medical Association Employees (Note 2)		137,148.99
Other trust funds		11,727.78
Accrued real estate taxes (contra)		8,500.00
Accounts and accrued interest payable		2,803.51
Deferred rental income		225.00
TOTAL LIABILITIES		$ 526,929.80
NET ASSETS		$1,164,616.69
CONSISTING OF:		
Contributed assets	$882,915.99	
Excess of income over expenditures	281,700.70	
TOTAL		$1,164,616.69

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

Statement of Income and Expenditures for the Year Ended June 30, 1960

INCOME (other than rentals):		
Interest on United States Treasury bonds		$ 28,025.00
Interest on contract and note		2,504.14
Dividends		900.00
Increase in cash value of life insurance policy surrendered		289.50
TOTAL		$ 31,718.64
EXPENDITURES (other than property expenses):		
Interest on ordinary loans	$ 446.46	
Fees	1,410.37	
Insurance	201.77	
Other	137.01	
TOTAL		2,195.61
REMAINDER		$ 29,523.03
DEDUCT:		
Net premiums on life and retirement insurance policies	$20,279.10	
Provision for the retirement or other benefit of an employee of an affiliated organization	3,000.00	
Total	$23,279.10	
Excess of expenses over income, property (Schedule 1)	11,151.09	34,430.19
EXCESS OF EXPENDITURES OVER INCOME, CURRENT YEAR		$ 4,907.16
EXCESS OF INCOME OVER EXPENDITURES:		
AT BEGINNING OF YEAR		$286,607.86
DEDUCT EXCESS OF EXPENDITURES OVER INCOME—CURRENT YEAR		4,907.16
AT END OF YEAR		$281,700.70

(Continued on next page)

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

Schedule 1

Statement of Property Income and Expenses for the Year Ended June 30, 1960

INCOME FROM RENTALS:		
California Medical Association	$24,256.00	
Others	11,402.36	
TOTAL		$35,658.36
EXPENSES:		
Utilities	$ 3,421.63	
Janitor service	4,275.90	
Repairs—Plumbing, venetian blinds, etc.	1,223.08	
Insurance	385.76	
Elevator inspection and service	493.60	
Supplies and other expense	716.07	
Total	$10,516.04	
Taxes (including penalty of $248.31)	8,525.19	
Interest on mortgage	4,231.22	
Interest on $270,000 note for purchase of property and making improvements thereon	14,128.00	
Total before depreciation	$37,400.45	
Depreciation	9,409.00	
TOTAL		46,809.45
EXCESS OF EXPENSES OVER INCOME		$11,151.09

NOTES TO FINANCIAL STATEMENTS, JUNE 30, 1960

NOTE 1.: The Trustees own all of the outstanding stock of the Pacific Magnetic Tape Equipment Co., which was formed for the purpose of merchandising magnetic tape equipment as an adjunct to the activities of the Audio-Digest Foundation, a wholly-owned subsidiary of the California Medical Association. An unaudited financial statement of the Pacific Magnetic Tape Equipment Co. as of June 30, 1960, reflects the net worth to be $18,919.12 at that date.

NOTE 2: The portion of the Trust Fund for California Medical Association Employees applicable to the retirement or similar benefit to Mr. and Mrs. Ben H. Read, amounting to $36,000 at June 30, 1960, has not been segregated from other assets of the corporation as directed by Chapter XVII of the Bylaws of the Corporation, which states: ". . . . All assets of this fund shall be held separate and apart from all other assets and property of the Corporation. . . ."

MEDICAL EXECUTIVES CONFERENCE

To the President and the House of Delegates:

The Medical Executives Conference met before each of the Council meetings to discuss county society problems and to act in an advisory capacity to the C.M.A. staff. With one exception the meetings were 100 per cent attended.

The subjects discussed included society sponsored group Insurance Plans, Legislative problems, general Public Relations, Physicians Placement Service, the C.M.A. TV Series and County Society's Public Service Committee operations.

Several ad hoc committees were appointed for special projects and performed their tasks with dispatch.

A number of new members of the conference were welcomed to the group.

The conference serves as a definite part of the C.M.A.'s activities.

Respectfully submitted,

ROBERT L. WOOD, JR., *Chairman*
Medical Executives Conference

LIAISON COMMITTEE TO THE CALIFORNIA HOSPITAL ASSOCIATION

To the President and the House of Delegates:

At the 1960 meeting of the House of Delegates, the Guiding Principles for Physician-Hospital Relationships were approved. During the past year, the Liaison Committee has been most active in meeting with county medical societies to explain the Guiding Principles and to urge their adoption and implementation by the medical staffs of hospitals. A copy of the Guiding Principles has been sent to each member of our association and has been reported on most favorably in several national publications. Approximately 30,000 copies of the Guiding Principles have been distributed.

Several counties have organized survey committees recommended by the Guiding Principles. The C.M.A. Council has authorized the Liaison Committee to appoint a state panel of consulting hospital surveyors. The committee is also in the process of drafting guides for the use of survey teams.

It is expected that in the coming year, the work of this committee will be greatly increased. It is hoped that all medical staffs of hospitals will adopt and implement the Guiding Principles.

I want to gratefully acknowledge the unselfish work and time given to this committee by Doctors Wadsworth and Halter, the other committee members; and Mr. William Whelan and Doctor Walter Batchelder of the C.M.A. staff who have worked long and hard on behalf of this committee.

Respectfully submitted,

JAMES C. MACLAGGAN, *Chairman*
Liaison Committee to the California Hospital Association

LIAISON COMMITTEE TO THE STATE BAR OF CALIFORNIA

To the President and the House of Delegates:

During the past year, the C.M.A. Liaison Committee to the State Bar of California met with the members of the Liaison Committee of the State Bar to confer with the California Medical Association. These committees have completed a survey conducted among those physicians and attorneys who have used the medical expert panels for malpractice cases. A report of this survey has been made to the Bar Association and printed in their *Journal;* the report to our Association was reported in the November 1960 issue of CALIFORNIA MEDICINE.

Based on the survey, the members of both liaison committees have concluded that a breakthrough has been achieved in securing voluntary physician testimony in meritorious cases. They have recommended that continued existence of the present program will not only result in an improvement in this segment of the administration of justice but will go far in improving the relationship between the two professions and with the public.

Resolution No. 23, passed by the 1960 House of Delegates, recommended that the Association initiate legislation to grant immunity from legal action for those actions of physicians' committees which are undertaken in the public interest. The C.M.A. Council referred this resolution to the liaison committees for study. The two committees recommended to their respective associations that the basic idea is in the public interest and should be supported in principle. It was further recommended that the chief counsel and the Commission on Public Policy take steps to have drafted an appropriate legislative proposal to carry out the intent of Resolution No. 23.

Resolution No. 67, passed by the 1960 House of Delegates, proposed that legislation be introduced to provide that plaintiffs' attorneys be required to post a $2,500 bond before filing a professional liability suit in the State of California. This resolution was referred to the liaison committees for study. Representatives of the State Bar pointed out that there is a general feeling among the members of the bar and judiciary that something constructive ought to be done to discourage malicious and frivolous prosecution in all fields. They also reported that the general subject is receiving a great deal of study by several committees of the State Bar incident to the proposal for the establishment of a personal injury commission.

In view of this fact the liaison committees recommended to the Council that the specific proposal made by Resolution No. 67 is too narrow and should not be pushed. It was further recommended that the present studies being undertaken by the State Bar of California should be followed with interest by the California Medical Association.

The work of these committees during the past year has been most interesting and worthwhile to both the Medical Association and Bar Association and their activities should be continued.

I am most grateful to the members of the C.M.A. Liaison Committee, Doctors J. Norman O'Neill, Rees B. Rees, Donald A. Charnock and Carl Goetsch, who have worked with such a fine spirit of cooperation.

Respectfully submitted,

FRANCIS E. WEST, *Chairman*
Liaison Committee to the State Bar of California

LIAISON COMMITTEE TO C.P.S.

To the President and the House of Delegates:

The Liaison Committee was created last year by action of the House of Delegates, the purpose of which was to establish a better rapport between the Association and C.P.S. and to review the various contracts being implemented by C.P.S. The Liaison Committee interprets the House of Delegates resolution as a charge to assist C.P.S. in leading the way in furnishing the most advanced medical coverage available to the public.

The past philosophy of C.P.S. is well known to all—that of providing prepaid medical care to low income groups through a service contract. From its inception, C.P.S. has made available prepaid medical care insurance on an indemnity basis to over-income ceiling groups.

The present philosophy of the operation of C.P.S. entails four essential features:

1. To provide for a mechanism for the prepayment of medical care costs.
2. To further the cause of prepayment in a manner that is advantageous to the subscribing member, the physician member and to California medicine.
3. To assist county medical societies in experimental programs.
4. To act as a fiscal agent for the physicians in California with respect to state and federal governmental programs.

In determining the philosophy for future operations of C.P.S., it is necessary to combine principles and philosophies. C.P.S. should continue to grow in proportion to anticipated increase in the state's population. As long as the competitive situations within the prepaid medical care field continue, there seems no reason to assume that any single insurance company or service organization, offering to the public prepaid medical care insurance, will grow unduly or assume a monopolistic position. The competitive market will be the factor which decides the ultimate size of C.P.S.

The committee is of the opinion that C.P.S. should be prepared to advance and grow in the field of prepaid medical care. It should, also, be prepared to continue to cooperate in greater degree with federal and state agencies.

The Liaison Committee has made numerous recommendations to the Commission on Medical Services and to the Council. Fundamentally, the recommendations have been geared to allowing C.P.S. to keep pace with current economic trends and developments so that it can meet consumer demands on a more realistic basis.

In the past, C.P.S. has been guided by a resolution which limited its sales efforts with respect to programs sold under the $6,000 family income ceiling on a county option basis. Technically, C.P.S. is not bound by the county option provision on contracts and the committee has reaffirmed the right of C.P.S. to act in the best interests of participating physicians and subscribers as determined by the Board of Trustees.

Additional recommendations have been made by C.P.S. in raising the level of fees paid by it to a more realistic level.

In the future, the Liaison Committee will be the body to conduct any polls of the members of the Association or participating physicians of C.P.S. regarding questions relating to C.P.S. The committee has reviewed and made recommendations on all House of Delegates resolutions referred to it. The committee has, also, worked closely with C.P.S. in contract demands as spelled out by the House of Delegates resolution.

The Council has approved the committee's reports and the actions of the Council, or of C.P.S., on these reports will be presented in other reports.

Respectfully submitted,

DONALD D. LUM, *Chairman*
Liaison Committee to C.P.S.

APPLICATION FOR HOUSING ACCOMMODATIONS

FOR YOUR CONVENIENCE in making hotel reservations for the coming meeting of the **California Medical Association,** April 30*-May 3, 1961, Los Angeles, hotels and their rates are at the right. Use the form at the bottom of this page, indicating your first and second choice. Because of the limited number of single rooms available, your chance of securing accommodations of your choice will be better if your request calls for rooms to be occupied by two or more persons. **All requests for reservations must give definite date and hour of arrival as well as definite date and approximate hour of departure; also names and addresses of all occupants of hotel rooms must be included.**

Ninetieth Annual Session

CALIFORNIA MEDICAL ASSOCIATION

Los Angeles, California

APRIL 30*-MAY 3, 1961

HOTEL ROOM RATES†

	Single	Twin Beds	Suites
AMBASSADOR HOTEL			
3400 Wilshire Boulevard			
Main Building	14.00-24.00	18.00-28.00	40.00-58.00
Garden Studios	22.00-34.00	24.00-36.00	54.00-66.00
CHAPMAN PARK HOTEL			
3405 Wilshire Boulevard	10.00-11.00	14.00-16.00	20.00-28.00
Bungalows		18.00	25.00-28.00
THE GAYLORD HOTEL			
3355 Wilshire Boulevard	9.00-10.00	12.00-15.00	Single: 25.00 Double: 35.00
HOTEL CHANCELLOR			
3191 West Seventh Street	8.00-10.00	12.00	
SHERATON-WEST			
(formerly Sheraton-Town House)			
2961 Wilshire Boulevard	12.50-20.00	17.50	34.00

ALL RESERVATIONS MUST BE RECEIVED BEFORE: APRIL 1, 1961

***April 29: House of Delegates will start with afternoon meeting Saturday, April 29.**

†The above quoted rates are existing rates but are subject to any change which may be made in the future.

CALIFORNIA MEDICAL ASSOCIATION—Dept. 74
693 Sutter Street
San Francisco 2, California

Please reserve the following accommodations for the 90th Annual Session of the California Medical Association, in Los Angeles April 30-May 3, 1961. (House of Delegates members: First meeting of House begins Saturday afternoon, April 29.)

Single Room $..... Twin-Bedded Room $.....

Small Suite $..... Large Suite $..... Other Type of Room $.....

First Choice Hotel..... Second Choice Hotel.....

ARRIVING AT HOTEL (date):.....Hour:.....A.M.....P.M. } Hotel reservations will be held until

Leaving (date) .....Hour:.....A.M.....P.M. } 6:00 p.m., unless otherwise notified

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Therefore, please include the names of both persons for each twin-bedded room requested. Names and addresses of all persons for whom you are requesting reservations and who will occupy the rooms asked for:

.....

.....

.....

.....

Individual Requesting Reservations—Please print or type Officer?..... Delegate?..... Alternate?.....

Name..... County.....

Address..... City and State.....

1961

Annual Session

AMBASSADOR HOTEL • LOS ANGELES

APRIL 30 to MAY 3

- Five Outstanding Guest Speakers
- General Scientific Meetings
- Specialty Scientific Meetings
- Postgraduate Courses
- Medical Motion Picture Symposia
- Technical Exhibits • Scientific Exhibits
- Presidents' Dinner Dance
  Sunday, April 30 • Cocoanut Grove
- House of Delegates
  Opening Session Saturday, 2:00 p.m., April 29
  Sunday, April 30, Tuesday Afternoon, May 2, and Wednesday, May 3
- Registration Daily
  8:30 a.m. to 5:00 p.m. . . . No Registration Fee

PLEASE MAKE HOTEL ROOM RESERVATIONS ONLY THROUGH C.M.A. OFFICE IN SAN FRANCISCO. USE RESERVATION REQUEST FORM ON PAGE 87.